

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02365

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------|-------------------------------------|
| 1. DECEASED-NAME (Type or print) | | First Ruth | Middle Elizabeth | Lost Allen | 2a. DATE OF DEATH Month February | Day 25 | Year 1969 | 2b. HOUR P 12:40 | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 12-23-1910 | | 6. AGE (In years lost birthday) 58 | | 7. IF UNDER 1 YEAR MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 401 Middle Street | |
| 14. FATHER'S NAME William | | Middle Henry | Lost Allen | 15. MOTHER'S MAIDEN NAME Mary | | First NMN | Middle Herbert | Address | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. ***** 215-14-2934 | | 17. INFORMANT Virginia Smith | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> | | 2 days | | | | | | | |
| 1550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple pulmonary metastatic Neoplasms</u> 1/2 year | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable primary or secondary hepatoma</u> 1/2 year | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic malnutrition for many years</u> | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1, 1965</u> , to <u>FEB. 25, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 25</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>R. L. Michels</u> | | 22c. DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <u>2/27/69</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS R. L. Michels MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-1-1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Fairview | | 23d. LOCATION (City or Town) Frederick | | (County) Fred. Md | (State) |
| 24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAR 3 1969 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02370 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02366

| | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------|--------------------------------------|------------------|-------------------------------------------------|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Lost | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> | Month | Day | Year | 2b. HOUR | |
| Luther Phillip Brown, Jr. | | | | | | Feb 24 | 1969 | 6 | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | | | | | |
| Male | Negro | 3-24-1934 | 34 | | | February | 24 | 1969 | 60 | M | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | | | | |
| Md | U.S. | | | Frederick | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | | D.O.A. Fred. Memorial | | | Construction | | | ***** | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER | | | | | | | |
| Md | Fred. | Frederick | | 60 Carver Apt. | | | | | | | |
| 14. FATHER'S NAME | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | First | Middle | Lost | | | | |
| Luther | Owen | Brown | | Ida | May | Snowden | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 16c. INFORMANT | ADDRESS | | | | | | | | |
| No | ***** | 214-28-5756 Ruth G. Brown | 60 Carver Apt. Fred. Md | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION ASPHYXIA - VOMITUS</u> | | | | | | | | | | | |
| 911X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| DIABETES MELLITUS | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | | 19b. DATE OF OPERATION | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | 22b. DATE SIGNED |
| ACTUAL SIGNATURE <u>Robert R.R. Roberts</u> | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) Robert R.R. Roberts M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 25 FEB 69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 2-28-1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Bartonsville | | | 23d. LOCATION (City or Town) Bartonsville | (County) | (State) | | |
| 24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md | | | ADDRESS | | | 25a. REC'D BY REGISTRAR MAR 3 1969 | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

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John Murray Co.

23-1000 100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.)

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 02371 | | 02367 | |
| 1. DECEASED-NAME (Type or print) | | First <i>Mary</i> | Middle <i>Etta</i> |
| 2. SEX | | 3. RACE <i>Female</i> | 4. RACE <i>white</i> |
| 5. DECEASED-NAME (Type or print) | | 6. DATE OF BIRTH <i>May 11, 1881</i> | |
| 7. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH <i>Frederick</i> | | 10. DATE OF DEATH Month <i>Feb</i> Day <i>11</i> Year <i>1969</i> | |
| 11. CITY OR TOWN OF DEATH <i>Frederick</i> | | 12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | |
| 13. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 14. FATHER'S NAME First <i>Owen</i> Middle <i>--</i> Lost <i>Duvall</i> | |
| 15. MOTHER'S NAME First <i>Marian</i> Middle <i>V.</i> Lost <i>Rae</i> | | 16. SOCIAL SECURITY NO. <i>219-14-9586</i> | |
| 17. INFORMANT <i>Mrs Herman Sirk, R#2, Woodbine, Md.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>adenocarcinoma of ascending colon</i> <i>1530</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause _____ lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | |
| 19. MEDICAL CERTIFICATION | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i> | |
| 21. DATE OF OPERATION | | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1) Generalized arteriosclerosis 2) Inactive pul. tuberculosis</i> | |
| 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 27. TIME OF INJURY HOUR A.M. Month Day Year P.M. _____ 19 | |
| 28. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 29. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 30. LOCATION Street or R.F.D. No. | | 31. CITY OR TOWN | |
| 32. COUNTY | | 33. STATE | |
| 34. I certify that (I) (this hospital) attended the deceased from <i>Jan 25</i> , 1969, to <i>Feb 11</i> , 1969, that (I) (we) last saw the deceased alive on <i>Feb 10</i> , 1969, and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death. | | 35. DATE SIGNED <i>11 Feb 1969</i> | |
| 36. SIGNATURE <i>Henry V. Chase</i> | | 37. DEGREE ATTENDING PHYS. | 38. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |
| 39. PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i> | | 40. ADDRESS <i>804 Toll House Ave Frederick, Md.</i> | |
| 41. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 42. NAME OF CEMETERY OR CREMATORIAL <i>Montgomery Meth.</i> | |
| 43. LOCATION (City or Town) <i>Clagettsville, Md.</i> | | (County) _____ (State) _____ | |
| 44. FUNERAL DIRECTOR ADDRESS <i>Olin L. Molesworth, Damascus, Md.</i> | | 45. REC'D BY REGISTRAR DATE <i>FFF 17 1969</i> | |
| 46. REGISTRAR'S SIGNATURE <i>Chandler Judge</i> | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------|----------------|
| 1. DECEASED-NAME (Type or print) | | First Vernon | Middle C. | Lost Burdette | 2a. DATE OF DEATH Month February | 2b. HOUR a.m. Day 1969 6:45 M | | |
| 3. SEX Male | | 4. RACE White | | S. DATE OF BIRTH December 29, 1902 | 6. AGE (In years at birthday) 86 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. CITY OR TOWN Frederick | | 13c. CITY OR TOWN Route 6 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Route 6 | | |
| 14. FATHER'S NAME First Charles | | Middle Burdette | Last | 15. MOTHER'S MAIDEN NAME First Bertha | | Middle | Lost Sulcer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214 10 2678 | | 17. INFORMANT Mrs. Mamie Burdette, Route 6, Frederick, Md. | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Kidney failure DUE TO, OR AS A CONSEQUENCE OF (c) HCVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one month one month 10 years + | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | |
| 22a. I certify that (1) (this hospital) attended the deceased from _____, 19 _____ to _____, 19 _____, that (1) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE W. J. Riddick | | DEGREE Willis J. Riddick-MD- or J.R. Poirer, M. D. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED Feb. 8, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS Frederick Medical Center, Frederick, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 10, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Mem. Gardens | | 23d. LOCATION (City or Town) Hansonville | (County) Frederick | (State) Md. |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland | | ADDRESS Fadley | | 25a. REC'D BY REGISTRAR FFB 13 1969 | | 25b. REGISTRAR'S SIGNATURE Charles J. Etchison | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
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FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. DECEASED-NAME (Type or print) | | | First W. | Middle Leslie | Last Burger | 2a. DATE OF DEATH Feb. 16 Month 69 Day 69 Year 3:45 M | 2b. HDUR P | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------|-------|
| 3. SEX Male | | 4. RACE White | 5. DATE OF BIRTH Oct. 7-1893 | | | 6. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED WIDOWED | | | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired grocer | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick | 13c. CITY OR TOWN Frederick | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 214 Norva Avenue | |
| 14. FATHER'S NAME Charles Edward Burger | | 15. MOTHER'S MAIDEN NAME Nettie Irene Bennett | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | 16b. SOCIAL SECURITY NO. WWar 1 215-26-1599 | | | 17. INFORMANT Mrs. Grace M. Burger-214 Norva Ave. Frederick | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKINSON'S DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>342X</u> (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNKNOWN</u> | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 12, 1968</u> , to <u>16 FEB 1969</u> , that (I) (we) last saw the deceased alive on <u>12 FEB 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>George I. Smith</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. George I. Smith-Jr. | | 22e. DEGREE ATTENDING PHYS. | 22c. MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED Feb. 17-1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 19-1969 | 23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | | | 23d. LOCATION (City or Town) Frederick, Md. 21701 | | |
| 24. FUNERAL DIRECTOR M.R.Etchison & Son | | ADDRESS Elwood T. Whitmore Frederick, Md. 21701 | 25a. REGISTRAR'S SIGNATURE FEB 19 1969 | | | 25b. REGISTRAR'S SIGNATURE George I. Smith, Judge | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02370

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please retain and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. DECEASED NAME (Type or print) | Arthur First C. C. | Middle | Lost | 2a. DATE OF DEATH Month Feb. 5 Day 69 Year | 2b. HOUR a 5:12 M |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (In years at birth) 65 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 MRS. HOURS MIN. |
| Male | White | Jan. 20- 1904 | 7. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick |
| 7a. BIRTHPLACE (State or foreign country) Md. | 7b. U.S.A. | 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Employee | 12b. KIND OF BUSINESS OR INDUSTRY Co.Roads |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. CITY OR TOWN Frederick | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 236 Dill Avenue | |
| 14. FATHER'S NAME Wm First H. Buxton | Middle | 15. MOTHER'S MAIDEN NAME Grace | Middle | Last | Troxell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. 214-10-1590 | 17. INFORMANT Mrs. Helen C. Buxton-236 Dill Ave.-Frederick- | Address Md. 21701 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>ventricular Aneurysm</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17, 1959</u> , to <u>Feb. 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Thomas E. Stone</i> | | DEGREE ATTENDING PHYS. | 22c. DATE SIGNED <i>5 Feb 69</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Thomas</i> | | 22e. ADDRESS <i>Stone</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Feb. 7-1969</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i> | 23d. LOCATION (City or Town) (County) (State) <i>Frederick, Md. 21701</i> | |
| 24. FUNERAL DIRECTOR <i>Elwood T. M.R. Etchison & Son</i> | | ADDRESS <i>Whitmore Frederick, Md. 21701</i> | 25a. READ BY REGISTRAR DATE <i>FEB 7 1969</i> | 25b. REGISTRAR'S SIGNATURE <i>Judge</i> | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

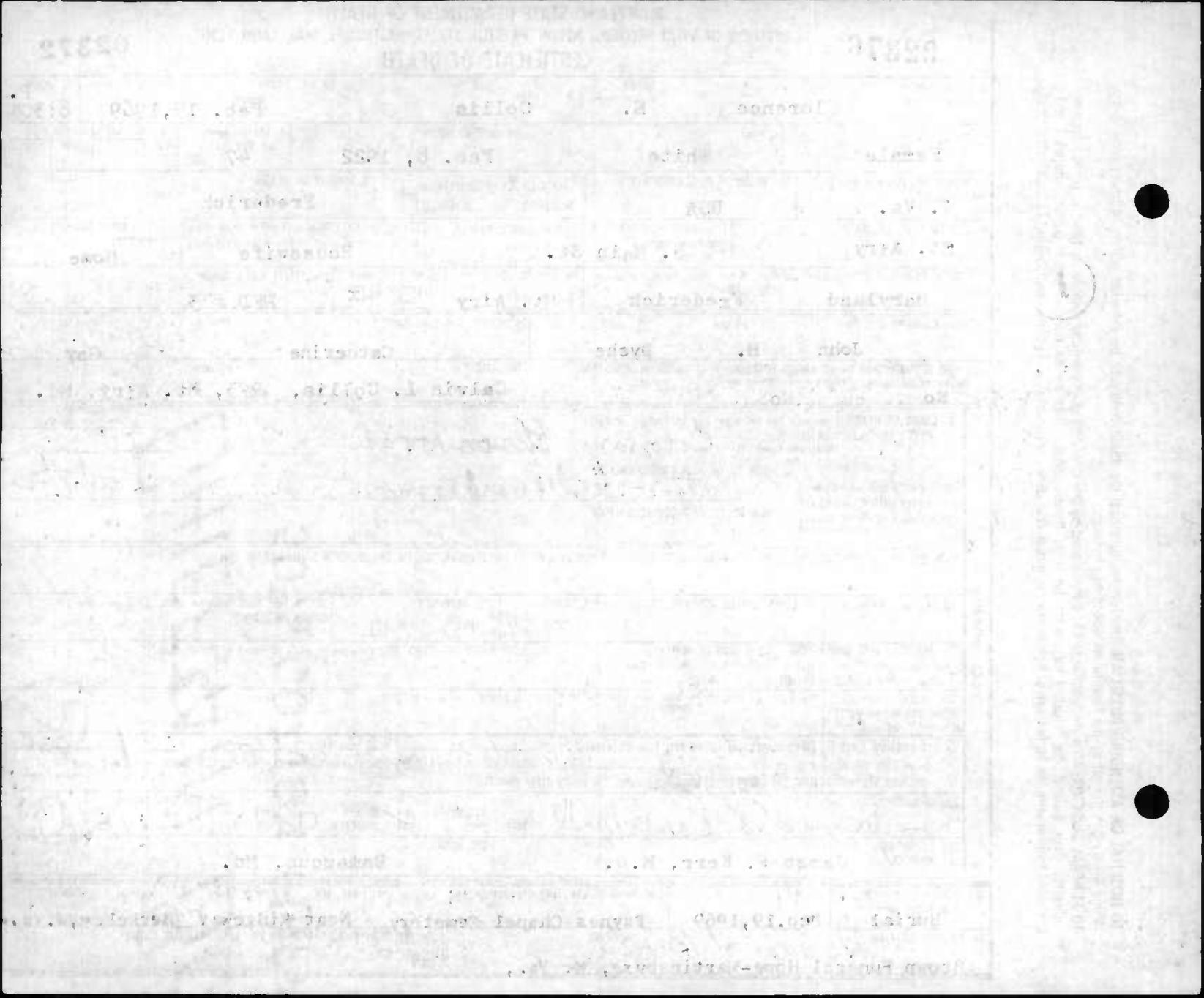
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| 02375 | | | | 02371 | | | |
| 1. DECEASED NAME (Type or print) | | First Aurelia | Middle M. | Last Callan | 2a. DATE OF DEATH Month 2 - 23 - 1969 Year | | 2b. HOUR 6:30 AM |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH 12-24-1889 | | 6. AGE (In years last birthday) 79 yrs. | |
| 7b. BIRTHPLACE (State or foreign country) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working time even if retired.) At home | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First John | | Middle Luskey | | 15. MOTHER'S MAIDEN NAME First Mary | | Last Starbrite | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown - | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT Dr. Margaret E. Callan, Daughter, Gaithersburg | | Address Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1550 | | 15. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | 16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) fibrosis of liver, gout, arteriosclerosis, diverticulitis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH? | |
| 21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23, 1969, to 2/23, 1969, that (I) (we) last saw the deceased alive on 2/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Frank D. D'Allesandro | | 22c. DEGREE ATTENDING PHYS. | | 22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22e. DATE SIGNED FEB 26 1969 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-26-1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Prince Georges Co. Md. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 1150 Wisc. Ave. N.W., Wash., D.C., 20016 | | ADDRESS | | 25a. RECEIVED BY REGISTRAR FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE Frank D. D'Allesandro | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 02376 | | | | 02372 | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Florence | Middle E. | Lost Collis | 20. DATE OF DEATH Month Feb. Day 15 , Year 1969 | | 2b. HOUR P. 8:30M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Feb. 8, 1922 | | 6. AGE (in years last birthday) 47 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | |
| 10. CITY OR TOWN OF DEATH Mt. Airy | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) S. Main St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Mt. Airy | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER RFD # 3 | | |
| 14. FATHER'S NAME First John | | Middle H. | Lost Dyche | 15. MOTHER'S MAIDEN NAME First Catherine | | Address Gay | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. No | | 17. INFORMANT Calvin L. Collis, R#3, Mt. Airy, Md. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| <p>22a. I certify that (I) (This hospital) attended the deceased from 2/17, 1969, to 2/15, 1969, that (I) (We) last saw the deceased alive on 2/14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p> | | | | | | | | | |
| 22b. SIGNATURE James P. Kerr, M.D. | | 22c. DEGREE ATTENDING PHYS. | | 22d. DATE SIGNED 2/15/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D. | | 22e. ADDRESS Damascus, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 19, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Paynes Chapel Cemetery | | 23d. LOCATION (City or Town) Near Ridgeway, Berkeley, W. Va. | | (County) (State) | |
| 24. FUNERAL DIRECTOR Howard R. Braxton | | ADDRESS Brown Funeral Home-Martinsburg, W. Va., | | 25a. REG'D BY REGISTRAR FEB 19 1969 | | 25b. REGISTRAR'S SIGNATURE | | | |



FOR STATE
HEALTH DEPT.

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24-hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02373

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Last | 20. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 20 1969 | Month Day Year | 2b. PM 4:30 |
| Thelma | | | Maude Copp | | | 2c. DATE PRONOUNCED DEAD Month Day Year Feb. 20 1969 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) 64 yrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2d. HOUR PM 11:30M | | |
| Female | White | Jan. 18, 1905 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick County | | |
| Guelph, Ont., Canada | | Canada | | | | | | |
| 10. CITY OR TOWN OF DEATH Emmitsburg | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) S. Seton Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ontario | | | 13c. CITY OR TOWN Willington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 14 Toop Road, Agincourt, Ont | |
| | | | Guelph | | | | | |
| 14. FATHER'S NAME Charles | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME Mildred | Middle | Last |
| | | | F. | Ritchie | | | | Shannon |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 439-148-933 | | | 17. INFORMANT Frederick A. Copp | | |
| | | | | | | ADDRESS 14 Toop Rd., Agincourt, Ont. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>MULTIPLE HEARTLED MYOCARDIAL INFARCTS</u> | | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | | Robert J. Thomas | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | 23b. DATE Feb. 22, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery | | |
| 24. FUNERAL DIRECTOR Clarence E. Wilson | | | ADDRESS Emmitsburg, Md. | | | 23d. LOCATION (City or Town) (County) (State) Guelph, Willington, Ontario | | |
| | | | | | | 25a. RECEIVED BY REGISTRAR DATE FEB 25 1969 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles J. Judge | | |

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DATE

CERTIFICATE OF DEATH

02374

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| 1. DECEASED NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR 9:15 | | | |
| Daisy Bendella Darr | | | February | 24 | 1969 | | | | | | | |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR | | IF OVER 24 HRS. | | | | |
| Female | White | February 8, 1891 | | | 78 | YEARS | MONTHS | DAYS | HOURS | MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | |
| Virginia | | USA | | WIDOWED | <input checked="" type="checkbox"/> | DIVORCED | <input type="checkbox"/> | Frederick | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Knoxville | | Box 267 - Route # 1 | | | Housewife | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Frederick | | Knoxville | YES | <input type="checkbox"/> | NO | Box 267 - Route # 1 | | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost | | | |
| Alonzo | | F. | Hackley | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | Route # 1 | | | | |
| No | | | | Mr. Millard Darr - | | Knoxville, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Influenza</i> | | | | | | | | | | | <i>4 days</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension</i> <i>Cardio</i> <i>Breuler</i> <i>Diabetic</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | YES | <input type="checkbox"/> | NO | <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | Street or R.F.D. No. | City or Town | | County | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/25/68</i> , 1965, to <i>2/25/69</i> , 1969, that (I) (we) last saw the deceased alive on <i>2/24/69</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>W.B. Carpenter M.D.</i> | | | | | | | | | | | 22c. DATE SIGNED <i>2/25/69</i> | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | <i>Lovettsville, Virginia.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION (City or Town) | | (County) | (State) | | | |
| Burial | | Feb. 27/69 | Union Cemetery | | | Lovettsville | | Loudoun | Va. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | Fred. Md. | | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | | |
| M. R. Etchison & Son | | 106 E. Church St. | | | | | DATE FEB 28 1969 | <i>Charles Judge</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------|
| 1. DECEASED-NAME (Type or print) | | First Alice | Middle Montgomery | Lost | 2a. DATE OF DEATH Month February | 2b. HOUR Day Year 10 1969 9:15 | |
| 3. SEX Female | | 4. RACE White | 5. DATE OF BIRTH June 17, 1890 | | 6. AGE (In years last birthday) 78 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Parkview Apt. #9 | |
| 14. FATHER'S NAME First John | | Middle Kitchen | 15. MOTHER'S MAIDEN NAME First Alice | | Middle Montgomery | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 560 05 6735 | 17. INFORMANT Harold Doane Parkview Apt. Frederick, Md. | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X | | 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Pulmonary embolism | | 492X DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours | |
| | | | | | | 2-years | |
| | | | | | | 10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 1969 , to 1969 , that (I) (we) last saw the deceased alive on 21/6 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE James B. Thomas | | DEGREE James B. Thomas, M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED Feb. 17, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS 228 N. Market Street, Frederick, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (specify) Burial | | 23b. DATE Feb. 18, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery | | 23d. LOCATION (City or Town) Frederick | (County) Frederick | (State) Md. |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. | | 25a. REC'D. BY REGISTRAR FEB 18 1969 | | 25b. REGISTRAR'S SIGNATURE John Judge | | | |

ROBERT TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02376

| | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------|--------------------------------------|-----------|-------------------------------------------------|
| 1. DECEASED-NAME (Type or Print) | | First | Middle | Lost | 20. DATE KNOWN OF ESTI- DEATH MATED | Month | Day | Year | 2b. HOUR | |
| | | Charles | Edward | Foreman, Jr. | <input checked="" type="checkbox"/> | 2 | 10 | 1969 | 4:45 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. DAYS | MIN | | | 2d. HOUR | |
| Male | Negro | 7-28-1955 | 13 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Frederick | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | 119 E. 5th street | | | None | | | ***** | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Md | | Frederick Fred. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 119 E. 5th Street | | | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | First | Middle | Lost | | |
| Charles | | Edward | Foreman, Sr | | Helen | Geneva | Thompson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give year or dates of service) | | 17. INFORMANT | | ADDRESS | | | | |
| No | | ***** | | ***** | | Fred. Md | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | CARBON MONOXIDE INTOXICATION | | | | | | | | |
| 890 X | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) | | (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 4:45 P.M. 2/10/1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No. HOME | | FIRE | | | | |
| 21g. CITY OR TOWN Frederick | | | | 21h. COUNTY Md | | 21i. STATE Md | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Robert J. Thomas | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIAL Eberneez | | | 23d. LOCATION (City or Town) Centerville | | (County) (State) Fred. Co. | | |
| Burial | | 2-12-1969 | | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | 25a. RECD BY REGISTRAR FEB 11 1969 | | 25b. REGISTRAR'S SIGNATURE Charles George | | | |
| C.E. Hicks, 111 Frederick, Md | | | | | | | | | | |

ROBERT TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

812 TOLL FREE 1-800-222-1234
FREDERICK, MARYLAND 21701
A15ME (5)
10M REV. 1/68

FOR STATE
HEALTH DEPT.

ROBERT J. THOMAS, M.D.
812 TOLL HOUSE AVENUE
FREDERICK, MARYLAND 21701
TOLL FREE 1-555-5555
TOM REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02377

| | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------------------------|----------|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE KNOWNED OF ESTI- DEATH MATED | Month | Day | Year | 2b. HOUR |
| Josephine Virginia Foreman | | | | 2 10 1969 4 PM | | | | 4 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | 2d. HOUR |
| Female | Negro | 8-28-1962 | 6 YRS. | MONTHS | DAYS | HOURS | MIN | 6 AM |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | |
| Md | U.S.A. | Frederick | | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | 119 E. 5th Street | | | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | | |
| Md | Frederick | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 119 E. 5th Street | | | | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | Last | |
| Charles | Edward | Foreman, Sr | | Helen | Geneva | Thompson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 17. INFORMANT | ADDRESS | | | | | |
| No | ***** | Helen Geneva Thompson | 119 E. 5th St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cuban Monile Intrication | | | | | | |
| 890X | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| | | (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| 19c. MEDICAL CERTIFICATION | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 4 PM 2/10 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FIRE | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME | | 21f. LOCATION Street or R.F.D. No. 119 E 5th | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Robert J. Thomas, M.D. | | | | | | |
| 23a. FUNERAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-12-1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Eberneez | | | 23d. LOCATION (City or Town) Centerville | (County) Fred. Md | (State) |
| 24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md | | ADDRESS | | | 25a. REC'D BY REGISTRAR FEB 11 1969 | 25b. REGISTRAR'S SIGNATURE Glenda Judge | | |

FOR STATE
HEALTH DEPT.

02382
M
PM Page

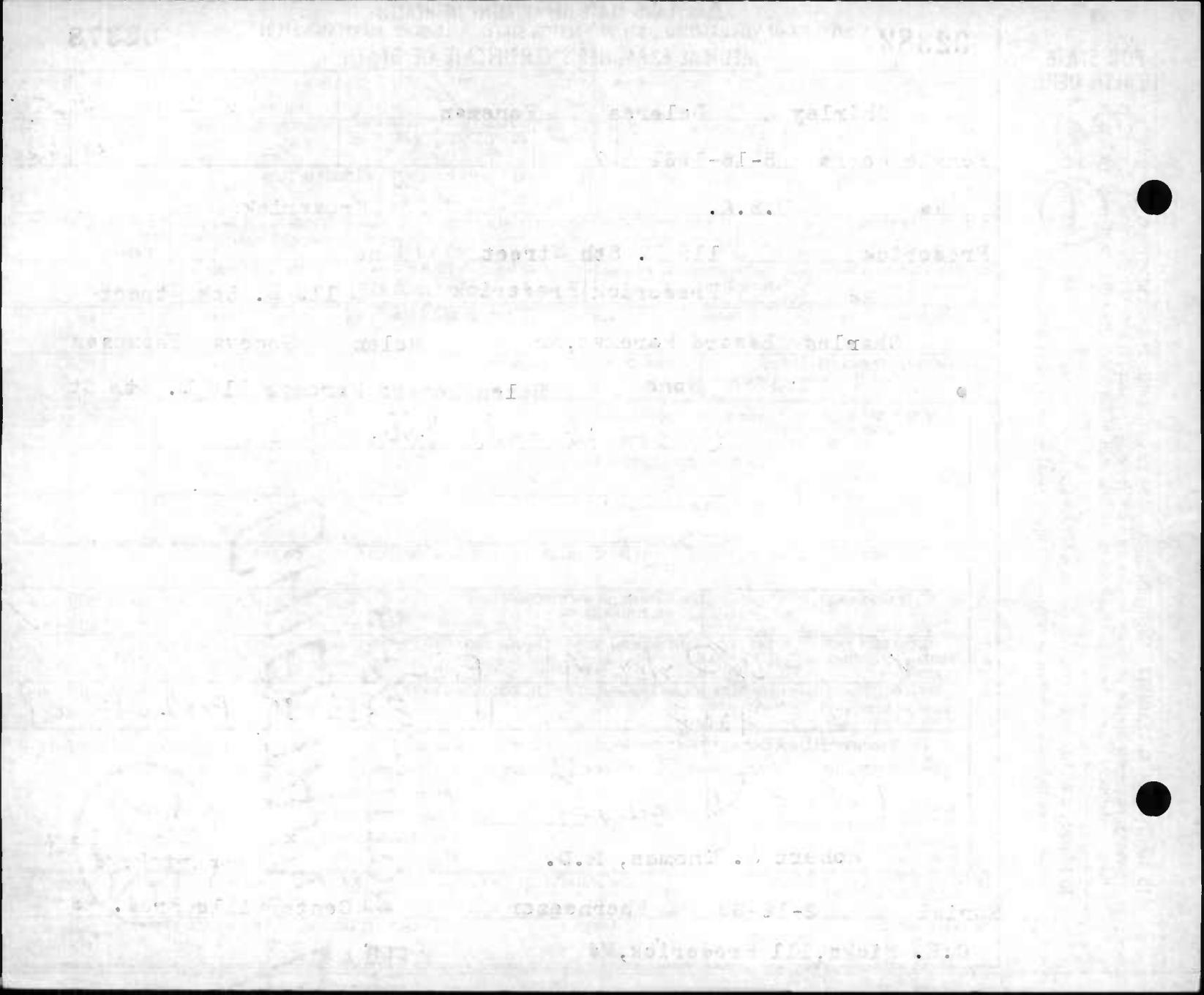
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02378

| | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------|---------------------------------------------------------------------|----------|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE KNOWN OF ESTI- DEATH MATED | Month | Day | Year | 2b. HOUR |
| Shirley | | Delores | Foreman | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS | | 4:30 PM |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (in years last birthday) | | | | | |
| Female | Negro | 5-16-1961 | 7 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | |
| Md | U.S.A. | | | Frederick | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Frederick | 119 E. 5th Street | | | None | | | *** | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | |
| Md | Frederick | Frederick | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 119 E. 5th Street | | | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | Last | |
| Charles Edward Foreman, Sr | | | | Helen Geneva Thompson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes give name or dates of service) | | | 17. INFORMANT | | | ADDRESS | |
| None | None | | | Helen Geneva Foreman 119 E. 5th St | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | |
| 19c. MEDICAL CERTIFICATION | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year 4:30 P.M. 2/10 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | Fine | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No. 119 E 5th St. Frederick Md | | | City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Robert J. Thomas | | | | | | | | |
| EXAMINER'S NAME (Type) Robert J. Thomas, M.D. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2-12-69 | 23c. NAME OF CEMETERY OR CREMATORIAL Eberneez | | | 23d. LOCATION (City or Town) Centerville Fred. Md | | |
| 24. FUNERAL DIRECTOR | | ADDRESS C.E. Hicks, 111 Frederick, Md | | | 25a. REC'D BY REGISTRAR FEB 11 1969 | | 25b. REGISTRAR'S SIGNATURE Charles J. Hicks | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02379

02383

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. DECEASED NAME (Type or print) | | First Annie | Middle B.ell | Last Funk | 2a. DATE OF DEATH Feb. Month 15 Day 1969 | 2b. HOUR 7.20 M | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH Feb. 7, 1885 | 6. AGE (In years last birthday) 84 | IF UNDER 1 YEAR MONTHS 8 DAYS | IF UNDER 24 HRS HOURS 10 MIN |
| 7a. BIRTHPLACE (State or foreign country) Frederick | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nsg. & Convalescent | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Brunswick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 13 East A St. |
| 14. FATHER'S NAME John | | Middle W. | Lost Demory | 15. MOTHER'S MAIDEN NAME Jane | | Middle P. | last Virts |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown | | 16b. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Eva Magalis | | Address Reservoir, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks <u>4/24</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Intratrochanteric Fracture of the left femur - Operation</u> | | | | | | | |
| 19a. DATE OF OPERATION Jan 20, '69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intratrochanteric Fracture | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 8:30 P.M. Jan 15, 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fall in home - fracture, lt. hip.</u> | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home | | 21f. LOCATION Street or R.F.D. No. 13 E A St. | City or Town Brunswick | County Frederick | State Md |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 18, 1969</u> , to <u>Feb 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>A. A. Pearre, Sr.</u> | | M.D. DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED Feb 15, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) A. A. Pearre, Sr. M.D. | | 22e. ADDRESS <u>Frederick, Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2/18/69 | 23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick, Maryland | | |
| 24. FUNERAL DIRECTOR Felt Funeral Home | | ADDRESS Brunswick, Maryland | | REGD BY REGISTRAR DATE FEB 18 1969 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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C. J. H. BROWNE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

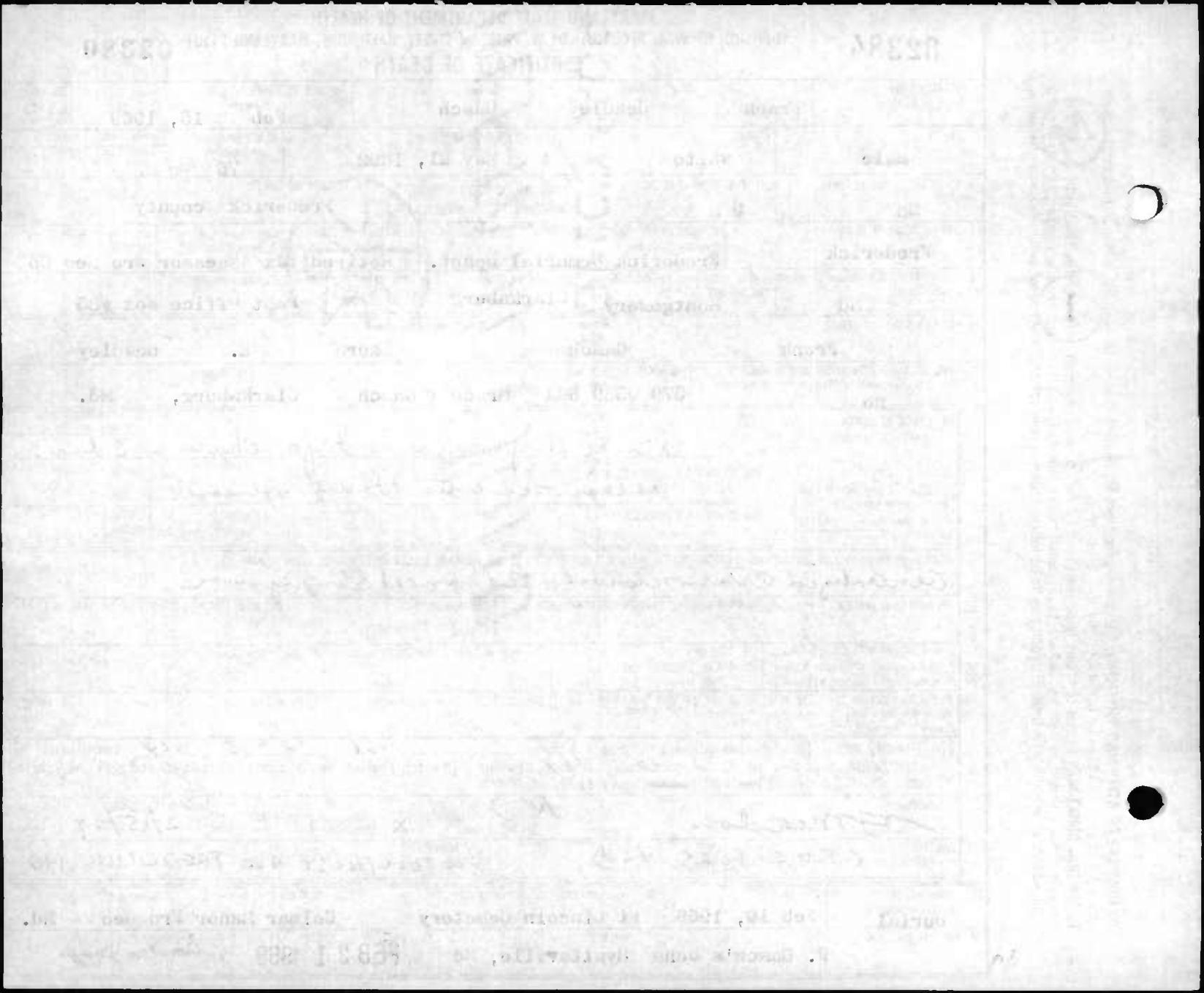
02384

02380

CERTIFICATE OF DEATH

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------|-------|
| 1. DECEASED-NAME (Type or print) | First Frank | Middle Headley | Last Gasch | 20. DATE OF DEATH Feb 15, 1969 | 2b. HOUR 1125A M | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH May 21, 1892 | | 6. AGE (In years lost birthday) 76 yrs. | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN | |
| 7b. BIRTHPLACE (State or foreign country) Md | 7b. CITIZEN OF WHAT COUNTRY? U S A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick county | | Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Tax Assessor | | 12b. KIND OF BUSINESS OR INDUSTRY Pro Geo Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Clarksburg | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Post Office Box #85 | | |
| 14. FATHER'S NAME First Frank | Middle Gasch | 15. MOTHER'S MAIDEN NAME Laura | First E. | Middle Headley | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | 16b. SOCIAL SECURITY NO. 579 0329 50A | 17. INFORMANT Grace T Gasch | Address Clarksburg, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized arteriosclerosis, Advanced Emphysema | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966, to 2-15, 1969, that (I) (we) last saw the deceased alive on 2-15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE G.F. MEADORS | M.D. DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED 2/15/69 | |
| 22d. PHYSICIAN'S NAME (Type) G.F. MEADORS, M.D. | 22e. ADDRESS 810 TOLLHOUSE AVE FREDERICK, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb 19, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery | 23d. LOCATION (City or Town) Colmar Manor | (County) Pro Geo | (State) Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | ADDRESS Hyattsville, Md. | | 25a. REC'D. BY REGISTRAR DATE FEB 21 1969 | 25b. REGISTRAR'S SIGNATURE Charles J. Gasch | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02381

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------|--------------------------------------|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR | | |
| | | Avery | Eugenia | Gorden | Month Feb. | Day 17 | | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) 72 | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | |
| Female | | white | Aug. 26, 1896 | | YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED WIDOWED | | 9. COUNTY OF DEATH | | | |
| West Virginia | | United States | <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED | | Frederick | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | Frederick Nursing Center | | Homemaker | | None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | | Frederick | Mt. Airy | NO <input checked="" type="checkbox"/> | Route # 4 | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | First | Middle | Lost |
| | | George | Bush | | Fannie | | Rowland | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | 219-20-0275 | | Mrs. Glenn Testerman Rt. # 4 | | Mt. Airy, Md. | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> APPROXIMATE INTERVAL 4123 BETWEEN ONSET AND DEATH <u>1 m/s</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Atherosclerotic heart disease</u> <u>year</u></p> <p>lost.</p> <p>(c)</p> | | | | | | | | |
| <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> | | | | | | | | |
| MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | |
| <p>22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 14</u>, 1968, to <u>Feb 17</u>, 1969, that (I) (we) last saw the deceased alive on <u>Feb 16</u>, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> | | | | | | | | |
| 22b. SIGNATURE | | <u>Henry V. Chase M.D.</u> | | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED <u>17 Feb 69</u> |
| 22d. PHYSICIAN'S NAME (Type) | | <u>Henry V. Chase</u> | | 22e. ADDRESS <u>804 Fall House Ave Frederick, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Burial 2-19-1969</u> | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Edge Hill Cemetery</u> | | 23d. LOCATION (City or Town) <u>Charles Town, West Virginia</u> | | (County) (State) | |
| 24. FUNERAL DIRECTOR | | ADDRESS <u>Robert E. Dailey & Son</u> | | 25a. REC'D. BY REGISTRAR <u>FEE 20</u> | 25b. DATE <u>1969</u> | 26b. REGISTRAR'S SIGNATURE <u>Charles J. Dailey</u> | | |

888-0333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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02386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02382

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First Edith | Middle M. | Lost Haller | 2a. DATE OF DEATH Month Feb. | 2b. HOUR Doy 69 | p M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Apr. 21-1885 | 6. AGE (In years lost birthday 83 | 7. CITIZEN OF WHAT COUNTRY Md. | 8. MARRIED WIDOWED NEVER MARRIED DIVORCED | 9. COUNTY OF DEATH Frederick | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | 12b. KIND OF BUSINESS OR INDUSTRY Md. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. CITY OR TOWN Frederick | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 241 S. Market St.-Frederick | 13f. STREET AND NUMBER Md. 21701 | | |
| 14. FATHER'S NAME Henry | First W. | Middle Haller | 15. MOTHER'S MAIDEN NAME Elizabeth | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. 214-54-0593 | 17. INFORMANT Frederick Mrs. Genora Hammond-241 S. Market St.- | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis, mural cerebral artery</i> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Previous cerebral Thrombosis</i> | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 19, 1962</i> , to <i>Feb 10, 1969</i> , that (I) (we) last saw the deceased alive on <i>Feb 10, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | 22b. SIGNATURE <i>Thomas E. Stone</i> | 22c. DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22d. DATE SIGNED <i>Feb. 11-1969</i> | | |
| 22d. PHYSICIAN'S NAME (Type) | Dr. Thomas E. Stone | 22e. ADDRESS 4 West 3rd. St.-Frederick, Md. 21701 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>Feb. 13-1969</i> | 23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i> | 23d. LOCATION (City or Town) <i>Frederick, Md. 21701</i> | (County) | (State) | | |
| 24. FUNERAL DIRECTOR <i>Elwood T. M.R. Etchison & Son</i> | ADDRESS <i>Whitmore Frederick, Md. 21701</i> | 25a. REC'D BY REGISTRAR DATE <i>FEB 13 1969</i> | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i> | | | | |

GRUSD

Scouting and Safety is the number one priority

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DEPARTMENT OF DEFENSE

Scouting and Safety

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Scouting and Safety

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

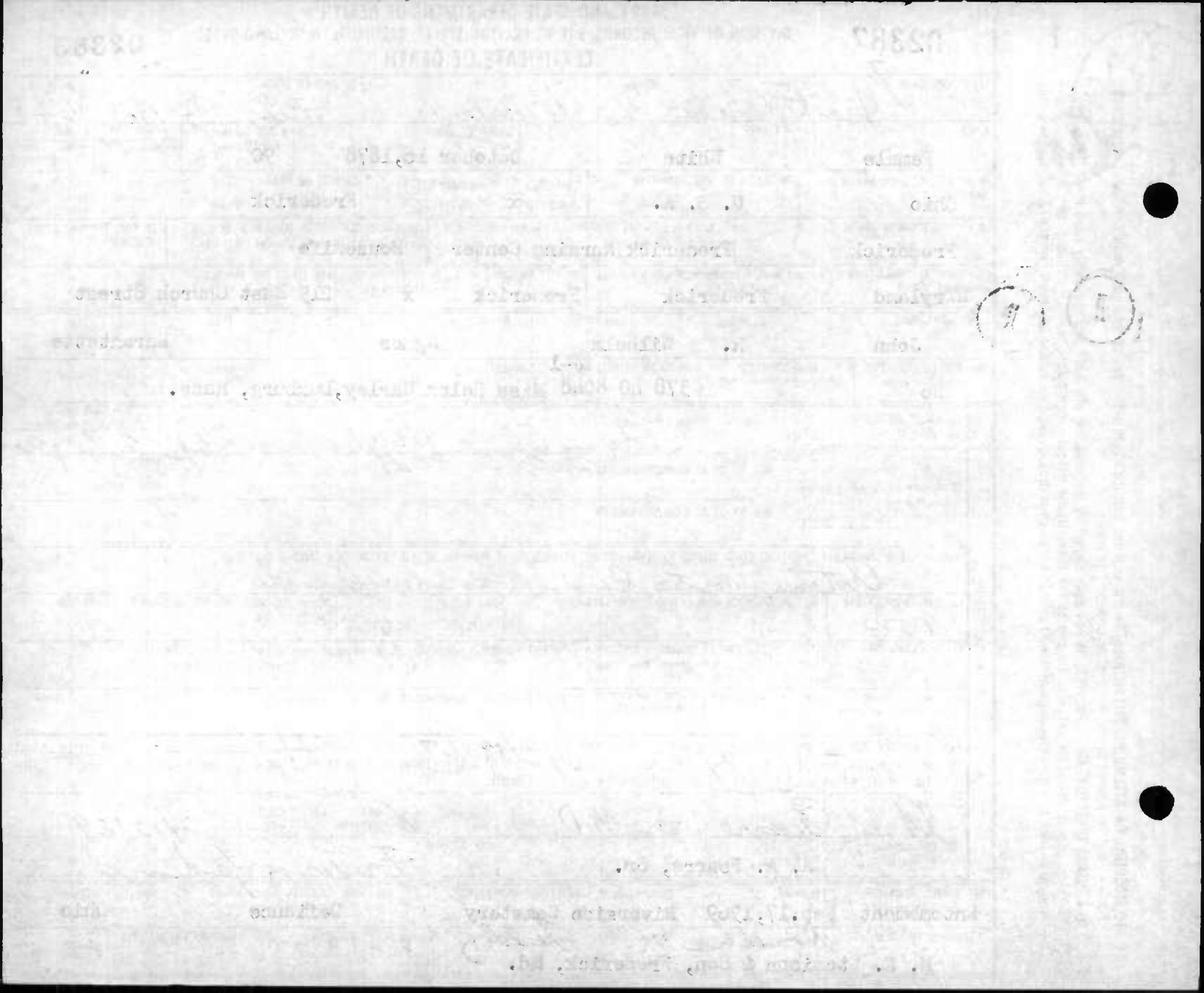
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02387

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02383

| | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------|--------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------|--------------------------------------|-------------------------------------------------|---------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR | | | |
| <i>Mrs Frances W. Harley</i> | | | | | | Feb. 13 1969 | Month Day | Year | 6:30 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | | | |
| Female | White | October 16, 1878 | | | 90 | MONTHS | YEARS | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | |
| Ohio | | U. S. A. | | | Frederick | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | Frederick Nursing Center | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | |
| STATE Maryland | | Frederick | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 215 East Church Street | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | Middle | | |
| | | John | R. | Wilhelm | Agnes | | | Marantette | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. <u>J-1</u> | | | 17. INFORMANT | | | Address | | |
| | | 378 40 8048 | | | Miss Helen Harley, Duxburg, Mass. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kidney Tumor (Hypernephroma L.)</u> | | | | | | | | | <u>2 yrs</u> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardio-vascular Disease</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| None | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | City or Town | | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/18/67</u> , 19 <u>67</u> , to <u>2/13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>A. A. Pearre Sr. M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22c. DATE SIGNED <u>2/13/69</u> | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | <i>Frederick, Md.</i> | | | | | |
| A. A. Pearre, Sr. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORI | | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Entombment | | Feb. 17, 1969 | | Riverside Cemetery | | | Defiance | | | Ohio |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | <i>Donald M. Fielder</i> | | | FEB 18 1969 | | <i>Frances W. Harley</i> | | | |
| | | M. R. Etchison & Son, Frederick, Md. | | | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME
(Type or Print) First Middle Last
James Franklin Harris

2a. DATE KNOWN
OF
ESTI-
DEATH MATED
2 28 1969

2b. HOUR
0800 M

3. SEX **M** 4. RACE **White** 5. DATE OF BIRTH **Nov. 1, 1899** 6. AGE (In years
(In months)
YRS) **61
1899
71**

7a. BIRTHPLACE (State or foreign
country) **Maryland** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. COUNTY OF DEATH **Frederick**

10. CITY OR TOWN OF DEATH **Frederick** 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) **Frederick Memorial** 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) **Farmer** 12b. KIND OF BUSINESS OR
INDUSTRY **Farm**

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE **Md** 13b. COUNTY **Frederick** 13c. CITY OR TOWN **Urbanna** 13d. INSIDE CITY LIMITS? YES NO 13e. STREET AND NUMBER **Rt. #2**

14. FATHER'S NAME First Middle Last 15. MOTHER'S MAIDEN NAME First Middle Last
Joseph M Harris **Mary Etta Collins**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) **No** 16b. SOCIAL SECURITY NO. **578-26-8774** 17. INFORMANT **Herbert Hyatt** ADDRESS **Damascus, Md**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **myocardial infarction**
DUE TO, OR AS A CONSEQUENCE OF
(b) **arteriosclerotic heart disease**
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
lost.
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? 20. AUTOPSY?
YES NO

21a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. **19** 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)

21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy Inspectian Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE **Robert R. Roberts** M.D. CHIEF MEDICAL EXAMINER 812 Toll House Ave
EXAMINER'S NAME (Type) **R. R. R. ROBERTS, M.D.** ASSISTANT MEDICAL EXAMINER 22b. DATE SIGNED **2/28/69**
ADDRESS (Street, city, town, or county) **Frederick, Md.**

23a. BURIAL CEREMONY
NAME (Specify) 23b. DATE **3-2-69** 23c. NAME OF CEMETERY OR CREMATORIAL
Potomac Methodist 23d. LOCATION (City or Town) (County) (State)
Potomac Montg. Md.

24. FUNERAL DIRECTOR **Robert A. Pumphrey** ADDRESS
7557-Wisconsin Ave., Bethesda, Md. 25a. REC'D BY REGISTRAR
DATE **Mar 5 1969** 25b. REGISTRAR'S SIGNATURE
John Clark

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02385

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR 7:15 P.M. |
| 2. WILLIAM EDWARD HARTSOUGH | | | | JEB. 23 1969 | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH May 14, 1904 | | 6. AGE (In years last birthday) 64 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Walkersville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3 Liberty St. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sander | 12b. KIND OF BUSINESS OR INDUSTRY Tool & Die | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Frederick | 13c. CITY OR TOWN Walkersville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 3 Liberty St. | |
| 14. FATHER'S NAME First Joseph | Middle Hartsough | Last | 15. MOTHER'S MAIDEN NAME First Mary | Middle | Last Kearns |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | 16b. SOCIAL SECURITY NO. before 1939 | 17. INFORMANT Mrs. Grace E. Hartsough, Walkersville, Md. | Address 1978 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of liver</u> 1978 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | | |
| 19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Severe anemia. Chronic bronchitis & pulmonary emphysema</u> | | | | | |
| 20. MEDICAL CERTIFICATION 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) (OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James E. Stoner, Jr. | | MD DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | STAFF PHYS. <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS WALKERSVILLE, Md. | | 22c. DATE SIGNED 2/25/69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2/26/69 | 23c. NAME OF CEMETERY OR CREMATORIAL Elmwood Cem. | 23d. LOCATION (City or Town) Walkersville, Frederick, Md. | (County) (State) |
| 24. FUNERAL DIRECTOR | | ADDRESS J. E. Barton, Walkersville, Md. 21793 | | 25a. REC'D BY REGISTRAR FEB 27 1969 | 25b. REGISTRAR'S SIGNATURE James E. Barton |

28880

110-10310012

1021

551
551
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02390
Item 1 Film G409 5/1/69 kk
Item 5 Film G409 2/13/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02386

CERTIFICATE OF DEATH

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME (Type or print) | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR 10:35 A.M. |
| CHARLES FRANKLIN HILTABRIDGE | | | | Feb. 6 1969 | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 1896 SEPT 12 - 1897 | 6. AGE (In years last birthday) 72 | 7. IF UNDER 1 YEAR MONTHS 0 | 8. IF UNDER 24 HRS. DAYS 0 |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH FREDERICK | Md. | |
| 10. CITY OR TOWN OF DEATH JOHNSVILLE | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAIN ST. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STATE ROADS COMM | 12b. KIND OF BUSINESS OR INDUSTRY ROADS | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY FREDERICK | 13c. CITY OR TOWN JOHNSVILLE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER MAIN ST. | |
| 14. FATHER'S NAME FRANK | 15. MOTHER'S MAIDEN NAME HILTABRIDGE | LILLIE | 16. SOCIAL SECURITY NO. 216-05-2083 | 17. INFORMANT Elfie | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES | 16b. SOCIAL SECURITY NO. W W I | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma - prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma - prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma - prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) arteriosclerosis | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>1/29 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | 211, 1969, to 2/6, 1969 | | | | |
| 22b. SIGNATURE M. E. Robertson MD | 22c. DATE SIGNED 2/6/69 | 22d. PHYSICIAN'S NAME (Type) ME ROBERTSON | 22e. ADDRESS New Windsor, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 2/10/69 | 23c. NAME OF CEMETERY OR CREMATORIAL MT OLIVET | 23d. LOCATION (City or Town) FREDERICK | (County) MD | (State) |
| 24. FUNERAL DIRECTOR D D Hertzler & Sons Union Bridge | ADDRESS | 25a. REC'D BY REGISTRAR FEB 10 1969 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1 02391 | | | | 02387 | | | |
| 1. DECEASED-NAME (Type or print) | | First Edna | Middle Mae | Lost | 2a. DATE OF DEATH Month Feb. Day 26 , Year 1969 | | 2b. HOUR 2 P.M. |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Sept. 17, 1908 | | 6. AGE (In years lost birthday) 60 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0 | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Md. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Adamstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Genoa | | Middle King | Lost | 15. MOTHER'S MAIDEN NAME First Vinnie | | Middle | Lost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT T. Maynard Kling, R#1, Adamstown, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of the lung</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>metastasis to the CNS.</i> (b) <i>metastasis to the CNS.</i> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| X MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. 10 Month Dec Day 26 Year 1968 P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC, 1968, to 26 FEB, 1969, that (I) (we) last saw the deceased alive on 26 FEB 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>George I. Smith</i> | | 14. DEGREE MD | | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type) | | George I. Smith, Jr. MD. | | 22e. ADDRESS Frederick, Md. | 22c. DATE SIGNED Mar 4 1969 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Mar. 1, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Mem. Gardens | | 23d. LOCATION (City or Town) (County) (State) Frederick, Md. | |
| 24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md. | | ADDRESS | | 25a. RECD. BY REGISTRAR MAR 4 1969 | | 25b. REGISTRAR'S SIGNATURE <i>George I. Smith, Judge</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------|
| 02392 | | 02388 | | | | |
| 1. DECEASED NAME (Type or print) | | First EDWARD | Middle L. | | | |
| 2. SEX | | 3. RACE | 4. DATE OF DEATH February 21, 1969 | | | |
| Male | | White | Lost 1 p.m. | | | |
| 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | 2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| November 26, 1876 | | 92 YRS. | 1 p.m. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| New Jersey | | U. S. A. | 9. COUNTY OF DEATH Frederick | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. CITY OR TOWN Frederick | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | 16. KIND OF BUSINESS OR INDUSTRY Md. | | | |
| First Joseph | | Middle Knisell | First Mary | | | |
| 2b. ADDRESS Frederick, Md. | | Jones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. 023 09 9957A | 17. INFORMANT Mrs. Catherine Wheeler, 620 Biggs Ave. | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) | | DUE TO, OR AS A CONSEQUENCE OF Cerebral Thrombosis | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis | | Years Years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 1969 , to 2/18, 1969 , that (I) (we) last saw the deceased alive on 2/18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE James B. Thomas | | 22c. DEGREE James B. Thomas, M. D. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | DATE SIGNED February 19, 1969 |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS 228 N. Market Street, Frederick, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 21, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cemetery | 23d. LOCATION (City or Town) Cambridge | (County) Mass. | (State) |
| 24. FUNERAL DIRECTOR Donald M. Etchison | | ADDRESS M. R. Etchison & Son, Frederick, Md. | | 25a. REC'D BY REGISTRAR Charles Judge | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

— 10 —

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02393

02389

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | First (Marie) | Middle A. | Lost Kraft Kroft | 20. DATE OF DEATH Feb Month 28 Day | 2b. HOUR 9:00 P M | | | |
| 3. SEX F | | 4. RACE W | 5. DATE OF BIRTH C/30/81 | | 6. AGE (in years last birthday) 87 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Czechoslovakia | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY at home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick, MD | 13c. CITY OR TOWN Frederick, MD | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 1507 Northgate Rd. | | | | |
| 14. FATHER'S NAME Unknown | | First Middle Lost Unknown - Kral | 15. MOTHER'S MAIDEN NAME First Marie | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO. 213 09 5485 | 17. INFORMANT daughter - Marie A. Primus | | Address XXXXXX | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | 485X Booncho pneumonia | | Congestive Heart Failure 36 hours | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF lost. | | (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Frederick right hip 1/1/69 | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION 1/3/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Frederick right hip | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1/1 1969 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fe/11 at home | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home | 21f. LOCATION Street or R.F.D. No. Mt. Airy | City or Town Frederick, Md. | County Md. | State Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1/69 to 2/28/69, that (I) (we) last saw the deceased alive on 2/28/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert H. D. Gram | | MD DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED 2/28/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert H. D. Gram | | 22e. ADDRESS Prost. Bldg. Frederick, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/4/69 | 23c. NAME OF CEMETERY OR CREMATORIAL Bohemian National Cem | 23d. LOCATION (City or Town) Baltimore, Md. | (County) | (State) | | | |
| 24. FUNERAL DIRECTOR Schimubek Funeral Home, Inc. 3331 Brehms Lane | | ADDRESS | | 25a. REC'D BY REGISTRAR Charles Judge | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |
| | | | | DATE MAR 4 1969 | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02390

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or offending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------|--|
| 02394 | | | 2a. DATE OF DEATH <i>Feb. Month 26 Day 69 Year</i> | | | 2b. HOUR <i>105 M</i> | | | |
| 1. DECEASED-NAME (Type or print) | | First Bessie | Middle Caroline | Last Krantz | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH June 14-1888 | | 6. AGE (In years last birthday) 80 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. CITY OR TOWN Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1005 Rosemont Ave. | |
| 14. FATHER'S NAME First Jacob | | Middle Stockslager | Last | 15. MOTHER'S MAIDEN NAME First Mary | | Middle Elizabeth | Last Winter | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 220-44-8253 | | 17. INFORMANT Miss Evelyn Krantz- 1005 Rosemont Ave. | | Frederick Address Md. 21701 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC NEPHRO SCLEROSIS | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL VASCULAR OCCLUSION WITH HEMIPLEGIA, UREMIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) AT HOME, FARM, STREET, FACTORY, | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. 810 Toll House Ave City or Town FREDERICK, MD. County Md. State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER, 1968 , to FEB. 26, 1969 , that (I) <input type="checkbox"/> last saw the deceased alive on FEB 26 1969 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>G.F. Meadors</i> | | M.D. DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. | |
| 22d. PHYSICIAN'S NAME (Type) G.F. MEADORS, M.D. | | 22e. ADDRESS 810 Toll House Ave FREDERICK, MD. | | 22f. DATE SIGNED 2/26/69 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 28-1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) Frederick | | (County) Frederick (State) Md. | |
| 24. FUNERAL DIRECTOR <i>Elywood T.</i> M.R. Etchison & Son | | ADDRESS Whitmore Frederick, Md. 21701 | | 25a. REGD. BY REGISTRAR MAR 3 1969 | | 25b. REGISTRAR'S SIGNATURE <i>James E. Etchison</i> | | | |

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02391

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Lost | 20. DATE KNOWN <input type="checkbox"/> Month Doy Year OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 22 169 3 A.M. | 2b. HOUR 2d. HOUR |
| Harold Louis Lowe | | | | | | | |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (in years last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Doy Year 19 | 2d. HOUR M |
| Male | White | Oct. 31, 1934 | 34 | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | |
| Maryland | | USA | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sheet metal worker | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13c. CITY OR TOWN Montgomery | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER RFD # 1 | |
| 14. FATHER'S NAME Louis E. Lowe | | | 15. MOTHER'S MAIDEN NAME Louise V. Barnhouse | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. No 214-30-0447 | | | 17. INFORMANT Mrs Bernice Lowe, R#1, Germantown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STOCK - 8129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MASSIVE PERITONEAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) TRAUMATIC LACERATION SM. BOWEL MESENTERY DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 2-22-1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) TWO VEHICLE COLLISION | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) HIGHWAY | | 21f. LOCATION Street or R.F.D. No. City or Town County State W.R. NEW MARKET - FREDERICK MD - | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature <i>Robert J. Thomas</i> M.D. | | | | | | | |
| EXAMINER'S NAME (Type) Robert J. Thomas, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 25, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Forest Oak | | 23d. LOCATION (City or Town) (County) (State) Gaithersburg, Md. | |
| 24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR FEB 25 1969 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02392

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------|
| 1. DECEASED NAME (Type or print) | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
| Effie | | F. | Mackley | Feb. 22 Doy 69 Year | 3:10 M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years (lost birthday) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| Female | White | June 28-1872 | | 96 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| Pa. | U.S.A. | | Frederick | | Md. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| F. Thurmont | 707 E. Main St. | | Homemaker | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| Md. | Frederick | Thurmont | YES <input checked="" type="checkbox"/> | 707 E. Main St. | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First Middle Last |
| Elias | | Renner | | Catherine Dusing | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | |
| No | 212-50-7635J1 | Mrs. Roger P. Heck-707 E. Main St. Thurmont- | Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Exhaustion following Cerebral Hemorrhage</u> APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH 6 mos | | | | | |
| 431.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral Arteriosclerosis</u> 1 year | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 2db. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>None 30</u> , 19 <u>68</u> , to <u>Feb 21 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 21</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>James K. Gray</u> | | DEGREE | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Dr. James K. Gray | | Thurmont- Frederick Co.- Md. 21788 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION (City or Town) | (County) (State) |
| Burial | Feb. 24-1969 | Mt. Olivet Cemetery | | Frederick | Frederick Md. |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REG. NO. FOR REG. CARD | 25b. REGULATOR'S SIGNATURE | | |
| M.R. Etchison & Son | Frederick, Md. 21701 | FEB 25 1969 | Charles Judge | | |
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MARYLAND STATE DEPARTMENT OF HEALTH

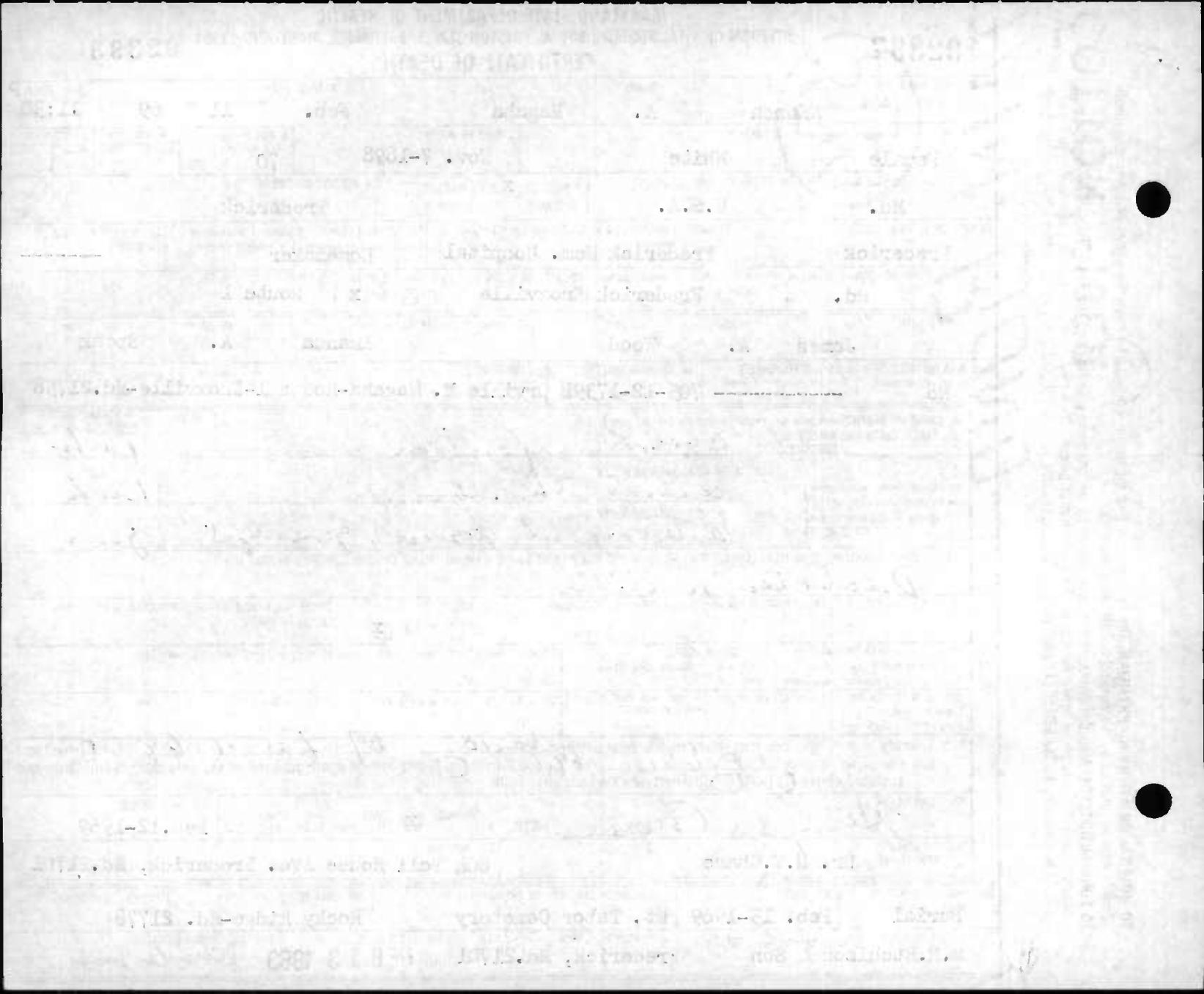
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02393

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------|-------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First Amanda | Middle A. | Lost Magaha | 2a. DATE OF DEATH Feb. 11 1969 | 2b. HOUR 11:30M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Nov. 7-1898 | | 6. AGE (In years (last birthday) 70 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Frederick | 13c. CITY OR TOWN Knoxville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Route 1 | | |
| 14. FATHER'S NAME James | First A. | Middle Wood | 15. MOTHER'S MAIDEN NAME Amanda | Middle A. | Lost Speak | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. 705-12-1739B | 17. INFORMANT Orville M. Magaha-Route 1-Knoxville-Md. 21758 | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> <u>433.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic disease, generalized</u> <u>years</u> | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>1 wks</u> <u>years</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 1969, to <u>Feb 11, 1969</u> , that (we) last saw the deceased alive on <u>Feb 11</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Henry V. Chase</u> | DEGREE ATTENDING PHYS. | MED. DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED Feb. 12-1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. H.V. Chase | 22e. ADDRESS 804 Toll House Ave. Frederick, Md. 21701 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb. 15-1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cemetery | 23d. LOCATION (City or Town) Rocky Ridge-Md. 21778 | (County) | (State) | |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | ADDRESS Frederick, Md. 21701 | 25a. REC'D BY REGISTRAR DATE FEB 13 1969 | 25b. REGISTRAR'S SIGNATURE <u>Charles George</u> | | | |

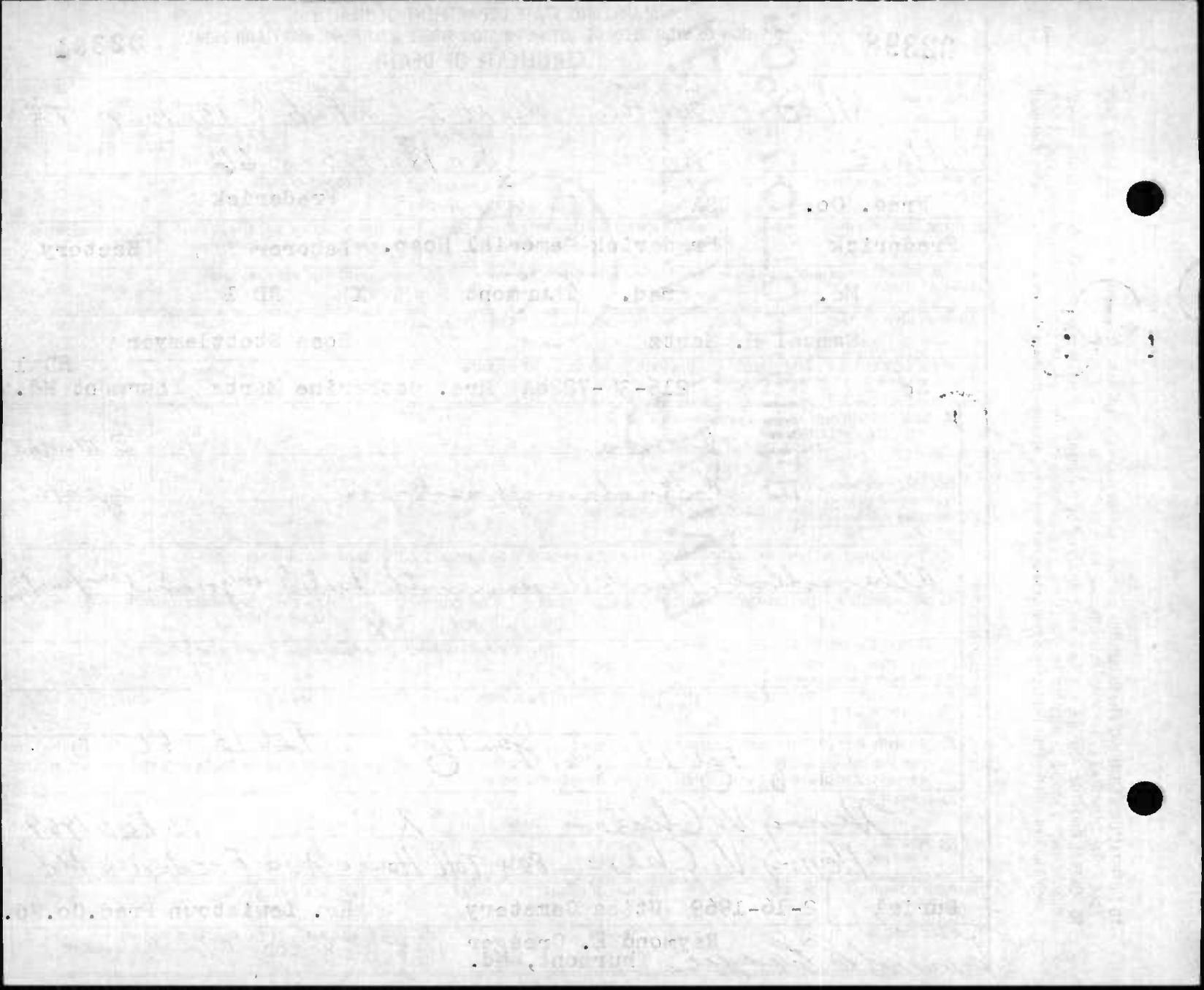


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~executed~~ within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------|--------------------------------------|-------------|-------------------------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | Month | Day | Year | 2b. HOUR | | |
| <i>Allen Benton</i> | | | <i>Martz</i> | | | <i>Feb 13</i> | <i>1969</i> | | | <i>7:25</i> | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | | | IF UNDER 24 HRS. HOURS | | | |
| <i>Male</i> | <i>white</i> | <i>Jan 18, 1903</i> | | | <i>66</i> YRS. | | | | | | | |
| 7b. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | | |
| <i>Fred. Co.</i> | | <i>USA</i> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | <i>Frederick</i> | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) | | | 12a. USUAL OCCUPATION (Kind of work done most of the time, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <i>Frederick</i> | | | <i>Frederick Memorial Hosp.</i> | | | <i>Laborer</i> | | | <i>factory</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| <i>Md.</i> | | <i>Fred.</i> | | <i>Thurmont</i> | | | | <i>RD 1</i> | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost | |
| <i>Samuel B. Martz</i> | | | | | | <i>Rosa Stottlemeyer</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| <i>No</i> | | | <i>215-36-7228A</i> | | | <i>Mrs. Catherine Martz</i> | | | <i>Thurmont Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> | | | | | | | | | | | <i>3 months</i> | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arterioloscleroticosis</i> | | | | | | | | | | | <i>year</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>atherosclerotic Heart Disease with healed myocardial infarction</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> , 19, to <i>Feb 13</i> , 1969, that (I) (we) last saw the deceased alive on <i>Feb 13</i> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Henry V. Chase</i> | | 22c. DEGREE ATTENDING PHYS. | | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | DATE SIGNED <i>13 Feb 1969</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS <i>Henry V. Chase 804 Toll House Ave Frederick, Md.</i> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL See 3 | | 23b. DATE <i>2-16-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Utica Cemetery</i> | | | 23d. LOCATION (City or Town) <i>Nr. Lewistown Fred. Co. Md.</i> | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR <i>Raymond E. Creager</i> | | ADDRESS <i>Thurmont, Md.</i> | | | 25a. REC'D BY REGISTRAR DATE <i>FEB 18 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Walter Gude</i> | | | | | |
| VR A15 45M - 1 | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02395

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

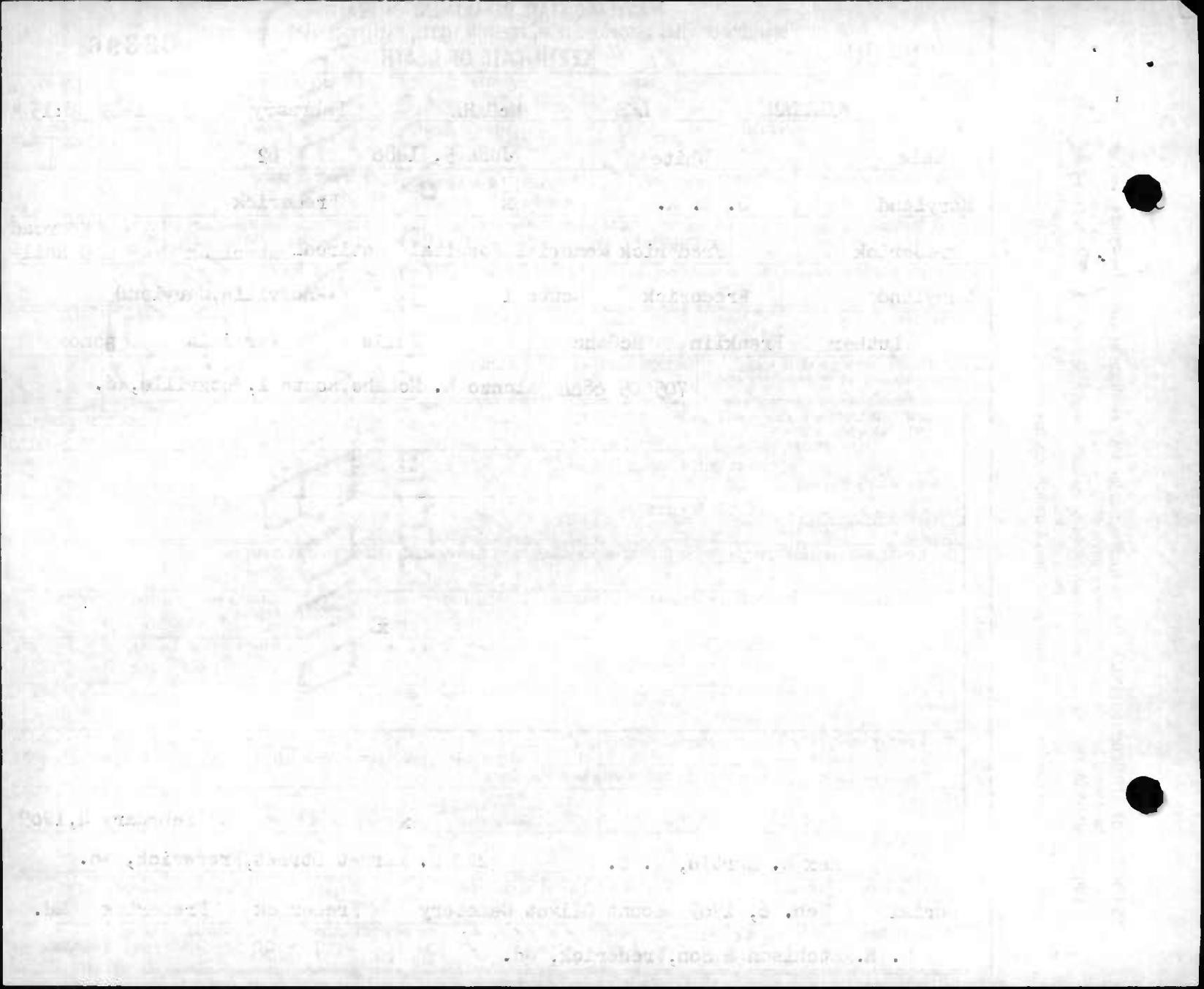
| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First Sister Anne Marie | Middle McDermott | Last McDermott | 2a. DATE OF DEATH Month 70 | 2b. HOUR Day 25 Year 1969 1:50 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH May 10, 1887 | | 6. AGE (In years last birthday) 81 | 7. IF UNDER 4 YEARS MONTHS DAYS HOURS MIN. |
| 7. BIRTHPLACE (State or foreign country) Pa. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED WIDOWED | NEVER MARRIED DIVORCED | 9. COUNTY OF DEATH Frederick | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. CITY OR TOWN Frederick | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER East Second Street | |
| 14. FATHER'S NAME Patrick | First McDermott | Middle | Last Elizabeth | Middle Gormley | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Convent records. | | | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterios - sclerotic C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute. (10 years.) |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma recto - sigmoid</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1969</u> , to <u>Sept. 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>Sept. 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Bernard O. Thomas Jr.</u> | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <u>3/28/69</u> | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS <u>Frederick, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE March 3, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Convent Cemetery | 23d. LOCATION (City or Town) Frederick | (County) Frederick | (State) Md. |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland | ADDRESS <u>Donald M. Fadley</u> | 25a. REC'D. BY REGISTRAR DATE MAR 4 1969 | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02396

10. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
11. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 20. DATE OF DEATH Month | 2b. HOUR a a.m. or p.m. |
| WILLIAM | | | LEE | McGAHA | February | 3 | 8:15 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Male | | White | | June 5, 1886 | | 82 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U. S. A. | | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Frederick | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS INDUSTRY | |
| Frederick | | Frederick Memorial Hospital | | Retired-Patrolman | | Road B & O Rail- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | Frederick | | Route 1 | | 13e. STREET AND NUMBER Knoxville, Maryland | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle |
| | | Luther | Franklin | McGaha | Julia | Virginia | Bond |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT | | Address | |
| | | 705 05 6844 | | Alonzo E. McGaha, Route 1, Knoxville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>284X</u> <u>Plastic anemia - questionably due to cancer of prostate</u> 3 months | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ last. (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-21-</u> , 19 <u>69</u> , to <u>2-3-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-2-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Rex R. Martin</u> | | DEGREE | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED February 4, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS 220 N. Market Street, Frederick, Md. | | | | | |
| Rex R. Martin, M. D. | | | | | | | |
| 23a. BURIAL, CREMATION, BEMOVAL (Specify) | | 23b. DATE Feb. 6, 1969 | 23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS M. R. Etchison & Son, Frederick, Md. | | 25a. REC'D BY REGISTRAR DATE FEB 7 1969 | | 25b. REGISTRAR'S SIGNATURE Charles George | |



Items 18&22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
5-13-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15ME (5)
REV. 1/68

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02397

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------|
| 1. DECEASED-NAME (Type or Print) | | First | Middle | Lost | 20. DATE KNOWN <input type="checkbox"/> Month Feb. 25 Year 169 | 2b. HOUR 8p.m. | |
| MARYBELLE | | (nmi) | | McKAY | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month February Day 25 Year 1969 | 2d. HOUR M |
| Female | White | Sept. 27, 1922 | 46 yrs. | | | | |
| 7. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | |
| West Virginia | | U. S. A. | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 205 South Jefferson Street | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 205 S. Jefferson Street | |
| 14. FATHER'S NAME E. L. White | | 15. MOTHER'S MAIDEN NAME Virginia | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT John W. McKay, Jr. Frederick, Maryland | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chemical intoxication DUE TO, OR AS A CONSEQUENCE OF 9509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | R.R.R. Roberts, Frederick Med. Center | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. <i>ATG</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | 22b. DATE SIGNED 26 FEB 69 |
| EXAMINER'S NAME (Type) | | R.R.R. Roberts, Frederick Med. Center | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE March 1, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md | |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland | | ADDRESS <i>Donald M. Etchison</i> | | 25a. REC'D. BY REGISTRAR DATE MAR 4 1969 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MESS

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------|---------|
| 1. DECEASED-NAME (Type or print) | | | First Mary | Middle Bertha | Lost Miller | 2a. DATE OF DEATH Month Feb. 7, 1969 Year | 2b. HOUR 4A M | | | |
| 3. SEX Female | | 4. RACE White | 5. DATE OF BIRTH Sept. 23, 1898 | | 6. AGE (In years lost birthday) 70 YRS. | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. DAYS | 2b. HOUR HOURS | 2b. HOUR MIN | |
| 7a. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | | | |
| 10. CITY OR TOWN OF DEATH Emmitsburg, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. # 2 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Emmitsburg | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER R.D. # 2 | | | | |
| 14. FATHER'S NAME John | | Middle D. | Lost Topper | 15. MOTHER'S MAIDEN NAME Annie | | Middle Zurgable | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 211-32-1979D | | 17. INFORMANT Mrs. Mary Topper, Emmitsburg, Maryland | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>arteriosclerotic C.V. disease several years</i> | | | | | | | | | | |
| 2509 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes mellitus several years</i> | | | | | | | | | | |
| (c) | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| MEDICAL CERTIFICATION | | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| | | 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 19, 1969</i> , to <i>Feb. 7, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 6, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| MEDICAL CERTIFICATION | | 22b. SIGNATURE <i>W.R. Cadle</i> | | | DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <i>7 Feb 69</i> | |
| | | 22d. PHYSICIAN'S NAME (Type) Dr. W. R. Cadle | | | 22e. ADDRESS Emmitsburg, Maryland | | | | | |
| MEDICAL CERTIFICATION | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 10, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL New St. Joseph's | | 23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md. | | (County) | (State) |
| | | 24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i> | | ADDRESS Emmitsburg, Md. | | 25e. REC'D BY REGISTRAR DATE <i>FEB 10 1969</i> | | 25f. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

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HISTOLOGY

82260

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|------------------------|--|
| 1. DECEASED-NAME (Type or print) | First Paincha | Middle LYNN | Last Myers | 2a. DATE OF DEATH Month Feb | Day 7 | Year 1969 | 2b. HOUR 6:45 A M | |
| 3. SEX FEMALE | 4. RACE Negro | 5. DATE OF BIRTH 11-29-1968 | | 6. AGE (In years last birthday) — YRS. | IF UNDER 1 YEAR MONTHS 2 | IF UNDER 24 HRS. DAYS 8 | 2b. HOUR HOURS 6 | |
| 7a. BIRTHPLACE (State or foreign country) Frederick | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED WIDOWED | 9. NEVER MARRIED DIVORCED | 9. COUNTY OF DEATH Frederick | Md. | | | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | 13b. CITY OR TOWN Frederick | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Route - 4 | | | | |
| 14. FATHER'S NAME CLARK | First DAVID | Middle Myers | Last | 15. MOTHER'S MAIDEN NAME Rachel | First Rebecca | Middle Holland | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. 7720 | 17. INFORMANT Rachel Myers - Rt. 4 - Fred. Md. | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>Central nervous system damage</u> DOUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1Wk | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> 1969, to <u>Feb 7</u> , 1969, that (I) (we) last saw the deceased alive on <u>Feb 1</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE C. E. Koenigsberg | 22c. DATE SIGNED Feb 11 1969 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) E. J. Koenigsberg | 22e. ADDRESS Frederick - Md Frederick Memorial Hosp. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify Burial) | 23b. DATE Feb 8-69 | 23c. NAME OF CEMETERY OR CREMATORIAL FAIRVIEW | 23d. LOCATION (City or Town) Frederick - Md | (County) Md | (State) | | | |
| 24. FUNERAL DIRECTOR C. E. Hicks III | ADDRESS Frederick - Md | 25a. REC'D BY REGISTRAR FEB 11 1969 | 25b. REGISTRAR'S SIGNATURE O. L. Miller, Judge | | | | | |
| 30M REV. 1 | | | | | | | | |

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MAIL TO A. J. H. H.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------|-------------------------------------------------------------------------|---------|
| 02404 | | | | 02400 | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | |
| GEORGE | | H. | NUSBAUM, SR. | | February | 28 | 1969 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | |
| Male | | White | | September 4, 1889 | | 79 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | U. S. A. | | | | Frederick | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | Frederick Memorial Hospital Retired | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Frederick | | Mt. Pleasant | | Route 1 | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | |
| | | Charles | Nusbaum | Sarah | | | Burrier | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | 212 24 5513 | | George H. Nusbaum, Jr. | | Mt. Pleasant, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Angestitis heart failure</i> | | | | | | | | |
| 4270 | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| last. (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 21a. MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/7/69</i> , to <i>2/8/69</i> , that (I) (we) last saw the deceased alive on <i>2/1/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>Robert S. Hughes</i> | | DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> | MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <i>Feb. 28, 1969</i> | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| Robert S. Hughes, M. D. | | 700 Montclaire Ave, Frederick, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION (City or Town) | (County) | (State) |
| Burial | | March 3, 1969 | | St. Peters Catholic Cem. | | Libertytown | Frederick | Md. |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Donald M. Etchison | | Faderley | | MAR 3 1969 | | <i>Robert S. Hughes</i> | | |
| M. R. Etchison & Son, Frederick, Md. | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

02405

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02402

| | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------|--------------|------------------------------------------------|--|------------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First Irene | Middle Daisy Maggie | Last Ohler | 2a. DATE OF DEATH Month Feb. | Day 28 | Year 1969 | 2b. HOUR 9 15 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH August 2, 1876 | | 6. AGE (In years last birthday) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Carroll Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> | | NEVER MARRIED DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | M | |
| 10. CITY OR TOWN OF DEATH Emmitsburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 311 East Main Street | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Emmitsburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 311 East Main Street | | | |
| 14. FATHER'S NAME First Uriah David Palmer | | Middle | | 15. MOTHER'S MAIDEN NAME First Margaret A. E. Fleagle | | Middle | | Lost | | Lost | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 218-50-7059 | | 17. INFORMANT Mrs. Nina G. Givens, 311 E. Main, Emmitburg | | Address Md., | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> <i>coronary thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22o. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>7/18/61</i> , 19:59, to <i>8/18/61</i> , 1961, that <input type="checkbox"/> (we) last saw the deceased alive on <i>8/15/61</i> , 1961, and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>George L. Moringstar</i> | | mb DEGREE | | ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR | | <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED <i>3/28/69</i> | |
| 22d. PHYSICIAN'S NAME (Type) George L. Moringstar | | 22e. ADDRESS Emmitsburg, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE March 3, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery | | 23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i> | | ADDRESS Emmitsburg, Md. | | 25a. REC'D. BY REGISTRAR DATE MAR 5 1969 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i> | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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02402

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First JAMES | Middle ANDREW | Lost PENROSE | 20. DATE OF DEATH Month 11 Doy 1969 YEAR | 2b. HOUR 6A.M. | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 2/1/1927 | | 6. AGE (In years 1st birthday) 42 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH FREDERICK | | Md. | |
| 10. CITY OR TOWN OF DEATH FREDERICK | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FREDERICK MEM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most recent job, even if retired) ENGINEER | | 12b. KIND OF BUSINESS OR FIRM AEROSTAT CORP. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY WASHINGTON | 13c. CITY OR TOWN HAGERSTOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 2222 CLOVELEAF RD. | | |
| 14. FATHER'S NAME JOSEPH | First A. | Middle PENROSE | 15. MOTHER'S MAIDEN NAME BEATRICE | 16. DR ISCOLE | Address HAGERSTOWN MD. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or no, or unknown YES | 16b. SOCIAL SECURITY NO. W.W.#2 | 17. INFORMANT 136-20-7090 | MRS. JANET C. PENROSE | Approximate Interval Between Onset and Death 8 hours | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic Aneurysm</u> <u>Circle of Willis</u> DUE TO, OR AS A CONSEQUENCE OF (c) ? | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb. 10, 1969</u> , to <u>Feb. 11, 1969</u> , that (1) (we) last saw the deceased alive on <u>Feb. 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>W.J. Riddick</u> | | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <u>Feb. 11, 1969</u> | |
| 22d. PHYSICIAN'S NAME (Type) DR. W. J. RIDDEICK | | 22e. ADDRESS FREDERICK MD. | | | | |
| 23a. BURIAL, CREMATION, BURIAL (Specify) | | 23b. DATE 2/13/69 | 23c. NAME OF CEMETERY OR CREMATORIUM ST. THOMAS CEM. | 23d. LOCATION (City or Town) ST. THOMAS | (County) PENNA. | (State) |
| 24. FUNERAL DIRECTOR <u>W. J. Norment, Hagerstown Md.</u> | | ADDRESS | 25a. RECEIVED BY REGISTRAR FEB 17 1969 | 25b. REGISTRAR'S SIGNATURE | | |
| | | DATE | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02403

02407

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. DECEASED NAME (Type or print) | | First <u>A/K</u> <u>Mary</u> Middle <u>Elsie</u> <u>Elsie</u> <u>Mary</u> <u>Posey</u> | Lost | 2a. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1969</u> | 2b. HOUR <u>4:45 M</u> |
| 3. SEX | | 4. RACE <u>Female</u> <u>Negro</u> | S. DATE OF BIRTH <u>6-21-1898</u> | 6. AGE (In years lost birthday) <u>70</u> YRS. | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u> |
| 7a. BIRTHPLACE (State or foreign country) <u>Md</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <u>Frederick</u> | |
| 10. CITY OR TOWN OF DEATH <u>Frederick</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>306 Madison St</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Domestic</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u> | | 13b. COUNTY <u>Frederick</u> | 13c. CITY OR TOWN <u>Frederick</u> | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER <u>306 Madison Street</u> |
| 14. FATHER'S NAME First <u>Isaac</u> Middle <u>NMN</u> Lost | | 15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u></u> Last <u>Margaret Williams</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service) <u>*****</u> | |
| 16b. SOCIAL SECURITY NO. <u>220-30-8818</u> | | 17. INFORMANT <u>Bessie Grayson</u> | | Address <u>Fred. Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>66 Cardio Resal & weak Dese</u> | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>4 yrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>Dec</u> Day <u>15</u> Year <u>1968</u> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u> | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 1968, to <u>Feb 3</u> , 1969, that (I) (we) last saw the deceased alive on <u>Feb 3</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>U.G. Bourne</u> | | 22c. DEGREE <u>ATTENDING PHYS.</u> | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <u>2-5-69</u> |
| 22d. PHYSICIAN'S NAME (Type) <u>U.G. Bourne, Jr</u> | | 22e. ADDRESS <u>30 W. All Saints St, Fred. Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2-7-1969</u> | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Fairview</u> | 23d. LOCATION (City or Town) (County) (State) <u>Frederick Fred Md</u> | |
| 24. FUNERAL DIRECTOR <u>C.E. Hicks, 111 Frederick, Md</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>11</u> | 25b. REGISTRAR'S SIGNATURE <u>John C. Judge</u> |
| VR A15 30M REV. 1/68 | | DATE <u>FEB 11 1969</u> | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02404

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED-NAME (Type or print) | | First Lertie | Middle Robert | Last Powers Jr. | 2a. DATE OF DEATH Month 2 Day 28 Year 69 | 2b. HOUR 5:30 P.M. | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH 6-28-21 | | | 6. AGE (In years last birthday) 47 | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | | Md. |
| 10. CITY OR TOWN OF DEATH Brunswick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 133 East Potomac | | | 12a. USUAL OCCUPATION (Kind of work done or kind of labor performed) Chief Train Dispatcher B&O R.R. | 12b. KIND OF BUSINESS OR INDUSTRY Freight Train Service | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Frederick | 13c. CITY OR TOWN Brunswick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 133 E. Potomac St. | | | |
| 14. FATHER'S NAME First Lertie | Middle Robert | Last Powers | 15. MOTHER'S MAIDEN NAME, First Nellie | Middle Mc Loughlin | Last last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-12-0659 | 17. INFORMANT Betty Jane Powers, Brunswick, Md. | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Angina Pectoris DUE TO, OR AS A CONSEQUENCE OF (c) Anxiety & Depression | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | 1 week | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (This hospital) attended the deceased from Jan. 2, 1967 , to Feb. 28, 1969 , that (I) (We) last saw the deceased alive on Feb. 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | 22c. DATE SIGNED 3-7-69 | |
| 22b. SIGNATURE | | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | | | |
| 22d. PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. | | 22e. ADDRESS Gum Spring Hollow Brunswick, Maryland 21716 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-4-69 | 23c. NAME OF CEMETERY OR CREMATORIAL National | | | 23d. LOCATION (City or Town) Worchester (County) (State) Worchester, Md. | |
| 24. FUNERAL DIRECTOR Feele Funeral Home | | ADDRESS Feele Funeral Home | 25a. REC'D BY REGISTRAR DATE MAR 6 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Indee | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02405

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 20. DATE OF DEATH Month | 21. HOUR Year | 22. HOUR M |
| Eula | | Virginia | Ridgeway | Feb 22 1969 2:15 P.M. | | | |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS HOURS MIN |
| Female | white | Dec. 10 1899 | | 69 yrs. | | | |
| 7b. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| maryland | W.S.A. | | | Frederick | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | Frederick Memorial | | | House wife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| maryland | Frederick | Brunswick | YES <input checked="" type="checkbox"/> | 17-10th ave | | | |
| 14. FATHER'S NAME | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | First | Middle | Lost |
| Frank McGuder Bell | | | | Rosa E Everhart | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | Address | | | |
| no | none | Ralph R Ridgeway | | Brunswick | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 2 WKS. | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease 2-3 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) with multiple myocardial infarctions | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20b. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 14, 1969, to Feb 22, 1969, that (I) (we) last saw the deceased alive on Feb 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | Henry V. Chase | DEGREE | ATTENDING PHYS. | MED. DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) | | Henry V. Chase | 22e. ADDRESS | Feb 22, 1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY, OR CREMATORIAL | 23d. LOCATION (City or Town) | County (State) | | |
| Buried | | 2-25-69 | Park Heights | Brunswick | County of Brunswick | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | | | |
| Feele Funeral Home Brunswick | | | FEB 26 1969 | W. Miller Judge | | | |

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FOR STATE
HEALTH DEPT.

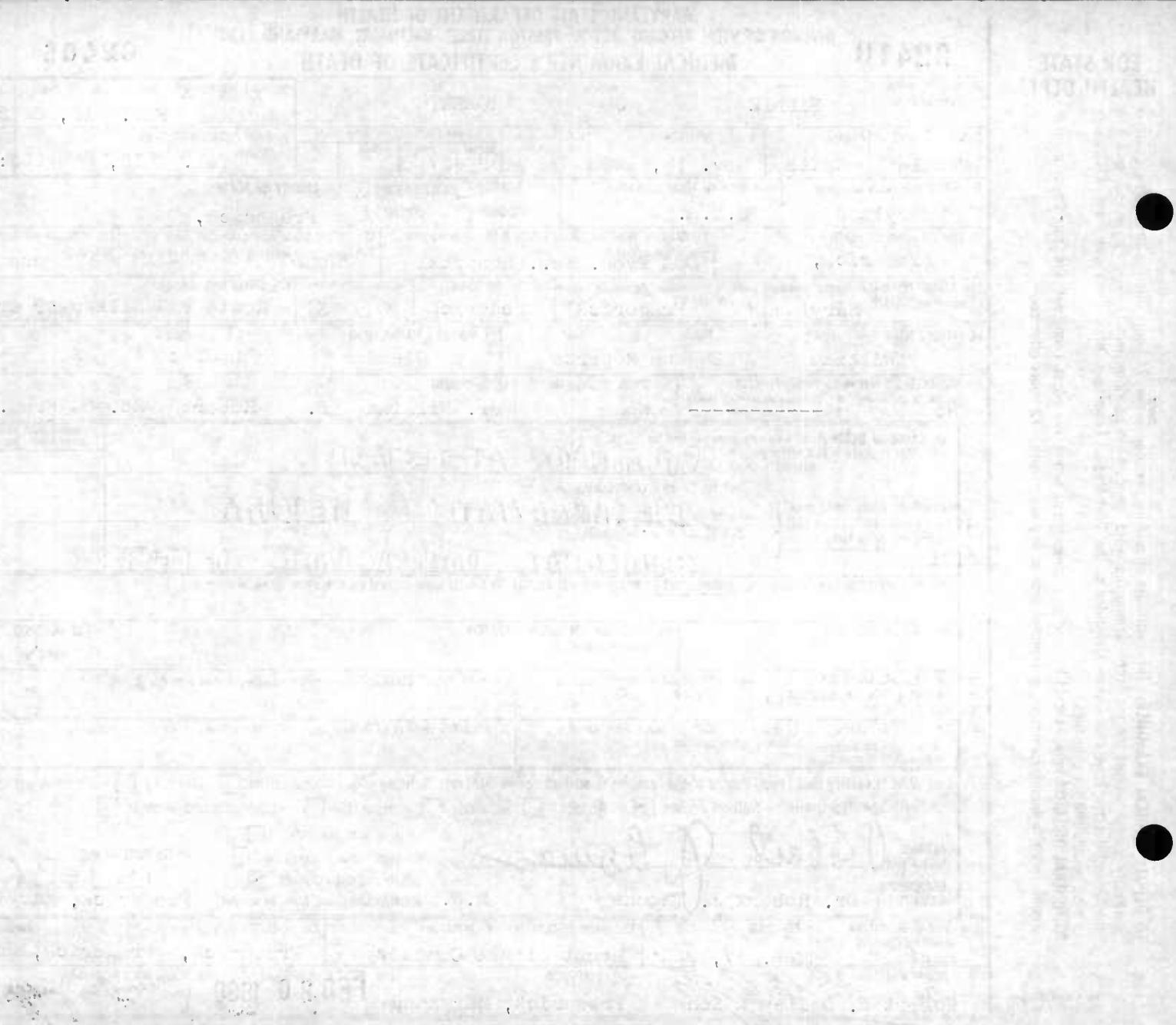
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------|
| 1. DECEASED-NAME (Type or Print) | First BILLIE | Middle JO | Last ROBERTS | 2a. DATE KNOWN OF DEATH ESTIMATED MATED | Month Feb. | Day 15 | Year 1969 | 2b. HOUR 5:45 a |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Nov. 18, 1968 | 6. AGE (In years last birthday) 0 yrs. | IF UNDER 1 YEAR MONTHS 2 | IF UNDER 24 HRS. DAYS 27 | HOURS MIN. | | 2d. HOUR 5:45 a |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED WIDOWED DIVORCED | 9. COUNTY OF DEATH Frederick, | 10. CITY OR TOWN OF DEATH Frederick, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Fred. Mem. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Route # 4 Ballenger Crk.Rd | 14. FATHER'S NAME William | First Eugene Roberts | Middle Glenda | Last Louise | Stine |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None | 17. INFORMANT Mr. William E. Roberts | ADDRESS Rt. # 4 Fred.Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>SUMMONARY ATELECTASIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>DIAPHRAGMATIC HERNIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGENITAL DIAPHRAGMATIC DEFECT</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <u>Robert J. Thomas</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 15 FEB 69 | | |
| EXAMINER'S NAME (Type) Dr. Robert J. Thomas | | M.D. | | ADDRESS (Street, city, town, or county) Frederick, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md. | | |
| 24. FUNERAL DIRECTOR <u>Robert E. Dailey</u> | | ADDRESS Robert E. Dailey & Son | | 25a. RECEIVED BY REGISTRAR FEB 20 1969 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1

0241.1

02407

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------|
| 1. DECEASED NAME (Type or print) | First | Middle | Lost | 20. DATE OF DEATH Month | 2b. HOUR 2:20 M |
| <i>Helen Virginia Shearer</i> | | | | Feb. 20 | Year 1969 |
| 3. SEX Female | 4. RACE White | S. DATE OF BIRTH Jan. 12-1915 | 6. AGE (In years last birthday) 54 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Registered Nurse | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Frederick | 13c. CITY OR TOWN Middletown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 305 Broad St. | |
| 14. FATHER'S NAME Clyde | First Middle C. Wachtel | 15. MOTHER'S MAIDEN NAME Elsie | Middle | Lost | Wilhlide |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-30-9249 | 17. INFORMANT F. Davis Shafer- Middletown, Md. 21769 | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Bronchial</i> 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypoperfusion left</i> ? | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1, 1968</i> , to <i>Feb. 1969</i> , that (I) (we) last saw the deceased alive on <i>2/20 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>C. Talbot Brice</i> | | 22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <i>2/20/69</i> | | |
| 22d. PHYSICIAN'S NAME (Type) A. Talbot Brice | | 22e. ADDRESS Jefferson- Md. 21755 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb. 23-1969 | 23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery | 23d. LOCATION (City or Town) Middletown- Md. 21769 | (County) | (State) |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | ADDRESS Frederick, Md. 21701 | 25a. REC'D BY REGISTRAR DATE FEB 24 1969 | 25b. REGISTRAR'S SIGNATURE <i>Etchison</i> | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02408

| | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------|--------------|--------------------------------------------------------------|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED MATED | Month | Day | Year | 2b. HOUR |
| | | GERALD McCORMICK SHEWBRIDGE | | | <input checked="" type="checkbox"/> | 2/8 | 19 | 69 | M |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (In years on birthday) | 7. IF UNDER 1 YEAR MONTHS | 8. IF UNDER 24 HRS. HOURS | | | | 2d. HOUR |
| Male | White | 3/21/1924 | 44 yrs. | | | | | | 1969 ? M |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH | | | | | | |
| W. Va. | U.S.A. | | Frederick | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Frederick | Frederick Memorial Hosp. | | | Machinist R.R. | Railroad | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Frederick Brunswick | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 207 N. Maple Ave | | | | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | Last | | |
| Clarence Reginald Shewbridge | | | | Anna Eleanor McCormick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 16c. INFORMANT | ADDRESS | | | | | | |
| Yes | WW II | 219-14-8534 | Geraldine Jones Brunswick, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> | | | | | | | | | |
| 5321 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Hemorrhagic Pancreatitis</i> | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF |
| | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <i>Penetrating Duodenal Peptic Ulcer</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | 20. AUTOPSY? |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | 22b. DATE SIGNED 9 FEB 69 |
| ACTUAL SIGNATURE <i>Robert J. Thomas</i> | | M.D. | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2/11/69 | | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Harpers Cemetery | | | 23d. LOCATION (City or Town) Harpers Ferry, W. Va. | | (County) (State) |
| 24. FUNERAL DIRECTOR Feele Funeral Home | | | | 25a. REC'D BY REGISTRAR Charles Judge | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | DATE FEB 19 1969 | | | | | |

6\2

ROBERT G. WILHAMS

100-18854-251

100-18854-251

ROBERT G. WILHAMS

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ROBERT G. WILHAMS

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ROBERT G. WILHAMS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------|
| 1. DECEASED-NAME (Type or print) | | First ROSEMARIE | Middle SHOMBER | Lost | 2a. DATE OF DEATH Month February | Day 20 | Year 1969 | 2b. HOUR 5:20 |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH June 26, 1929 | | | 6. AGE (In years last birthday) 39 | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS. HOURS 0 | IF UNDER 24 HRS. MIN 0 |
| 7. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick, | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 817 Clearfield Road | | | |
| 14. FATHER'S NAME First Joel | Middle Radford | Lost | 15. MOTHER'S MAIDEN NAME First Middle Helen Rohr | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-28-0840 | 17. INFORMANT Mr. Earl Wm. Shomber | Address 817 Clearfield Rd. Md. | | | Fred. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509 Hypertension &uria DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Diabetes mellitus (b) 27 yrs DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Blindness R eye + partial blindness L eye + foot amputation | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | | County | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-26, 1968 to 2-20, 1969 , that (I) (we) lost saw the deceased alive on 2-20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Rex R. Martin | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED Feb. 20, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin | M.D. | 22e. ADDRESS 220 North Market Street | Fred. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2-24-1969 | 23c. NAME OF CEMETERY OR CREMATORIY Lake View Cemetery | 23d. LOCATION (City or Town) Baltimore, Baltimore, Md. | (County) Baltimore, Baltimore, Md. | | (State) | | |
| 24. FUNERAL-DIRECTOR Robert E. Dailey & Son | ADDRESS Frederick, Maryland | 25a. FILED BY REGISTRAR FEB 25 1969 | 25b. REGISTRAR'S SIGNATURE Charles J. Judge | | | | | |

1953
Aug 13
Tangierfoot - up several times + up + down

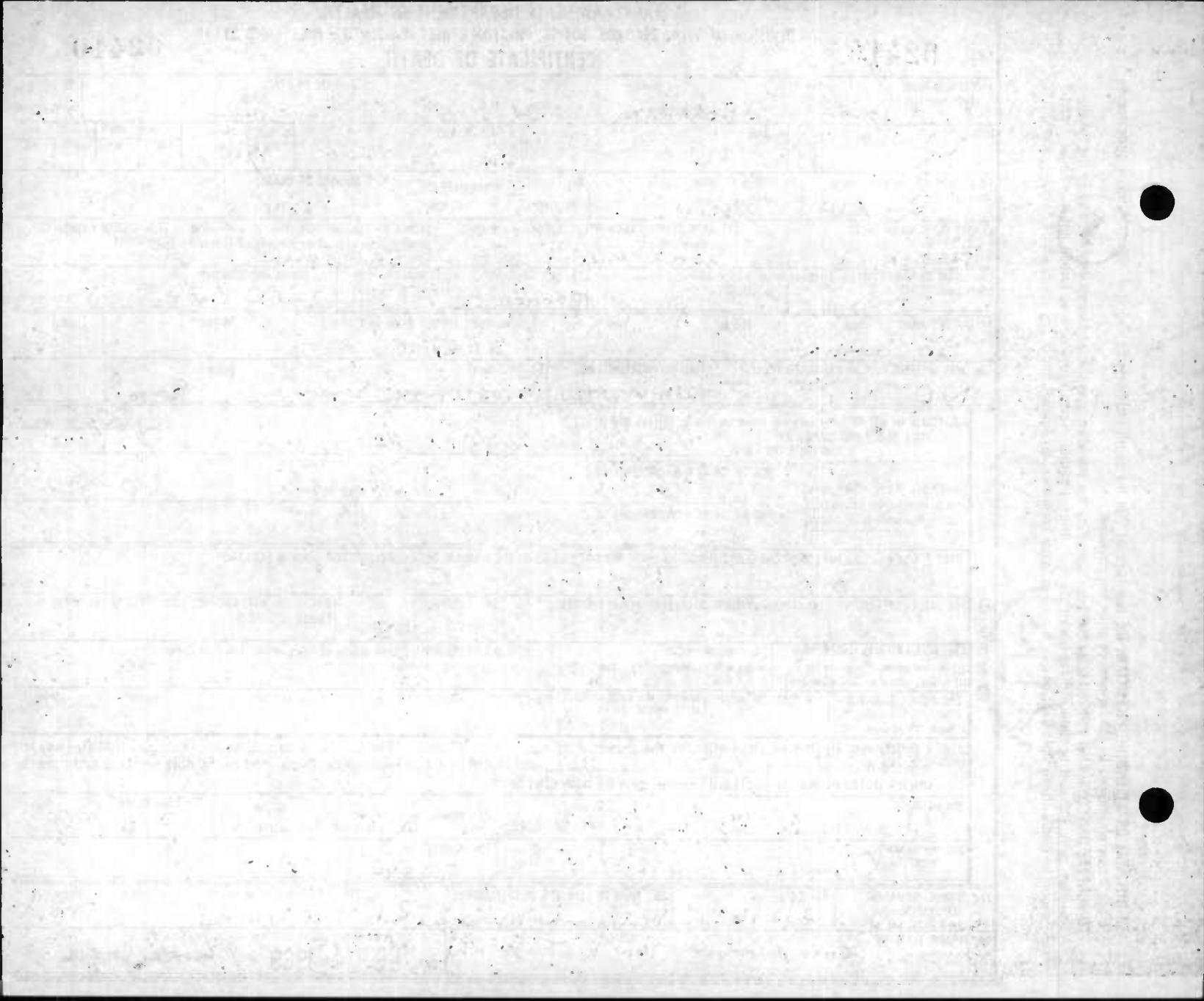
Aug 13

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02410

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, **filed in** by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, **Pages 1 and 2**, should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------|-----------------------------------------|--------------------------------------------------------------------|-------------------|--|
| 1. DECEASED NAME (Type or print) | First JACOB | Middle ABRAHAM | Lost SIMON | 20. DATE OF DEATH Month February | Day 1 | Year 1969 | 2b. HOUR 940 A.M. | | | |
| 3. SEX M | 4. RACE W | S. DATE OF BIRTH APRIL 22, 1889 | | | 6. AGE (In years last birthday) 79 | YRS. | IF UNDERR 1 YEAR MONTHS 00 | IF UNDERR 24 HRS. HOURS 00 | MIN. 00 | |
| 7a. BIRTHPLACE (State or foreign country) RUSSIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH FREDRICK | | | | |
| 10. CITY OR TOWN OF DEATH FREDRICK | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 320 N. MARKET ST | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | 13b. COUNTY Frederick | 13c. CITY OR TOWN FREDRICK | 13d. INSIDE CITY LIMITS? YES | 13e. STREET AND NUMBER 220 N. MARKET ST | | | | | | |
| 14. FATHER'S NAME First Solomon | Middle | Last | 15. MOTHER'S MAIDEN NAME First Freida | Middle | Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-10-3412 | 17. INFORMANT Mrs Anna Simon | Address Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> 492X last. (b) Ch. Pulmonary, Encephalitis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) Influenza, pneumonia | | | | | | | | 10+ yrs. | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 Jan , 1969, to 1 Feb , 1969, that (I) (we) last saw the deceased alive on 27 Jan , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED 1 Feb. 1969 | | |
| 22b. SIGNATURE Charles H. Conley, Jr. M.D. | 22c. DEGREE MD. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) CHARLES H. CONLEY, JR. | 22e. ADDRESS FREDRICK, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/2/69 | 23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Park | 23d. LOCATION (City or Town) Fredrick | (County) MD | (State) MD | | | | | |
| 24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc. | ADDRESS 9610 Resthaven Rd | 25a. REC'D BY REGISTRAR DATE 1 Feb 4 1969 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |



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6
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2
ROBERT 812 TOLL FREE 1-5ME (5)
FREDERICK MARYLAND 10M REV. 1/68

FOR STATE
HEALTH DEPT.

02415

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02411

| | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------|
| 1. DECEASED-NAME (Type or Print) | | First | Middle | Lost | 20. DATE KNOWN <input type="checkbox"/> Month Day Year | 2b. HOUR <input type="checkbox"/> 10 AM | | |
| | | CLYDE | WASHINGTON | SMITH | OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2 8 1969 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR <input type="checkbox"/> 11 AM | | |
| Male | White | Nov. 1, 1888 | 80 YRS. | | 2 | 8 1969 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Frederick | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| Frederick | | east Patrick Street | | | Retired | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | |
| Maryland | | Frederick | Ijamsville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Ijamsville, Maryland | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | First | | |
| | | William | C. W. | Smith | Adelaide | Middle | | |
| | | | | | | Lost | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | ADDRESS | | | |
| No | | 217 16 2149 | | William Franklin Smith, New Market, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4124</u> (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | 22b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | | | 22b. DATE SIGNED 2-8-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 11, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md. | | |
| 24. FUNERAL DIRECTOR Donald M. Etchison | | ADDRESS Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| | | | | FEB 13 1969 | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------|--------------------------------------|------------------|
| 02416 | | 02412 | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | | | | |
| Murray | | F. | Stocksdale | | | | |
| 2a. DATE OF DEATH | | Month | Day | | | | |
| Feb 19 | | 1969 | Year | | | | |
| 2b. HOUR | | M | | | | | |
| 3. SEX | | 4. RACE | S. DATE OF BIRTH | | | | |
| Male | | White | May 25, 1890. | | | | |
| 6. AGE (In years lost, birthday) | | 7. IF UNDER 1 YEAR MONTHS | 8. IF UNDER 24 HRS. DAYS HOURS MIN. | | | | |
| 78 | | YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| Maryland | | USA | 9. COUNTY OF DEATH | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired.) | | | | |
| Frederick | | Frederick Nursing Center | Retired Accountant | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | | | |
| Md. | | Thurmont | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13b. COUNT | | 13e. STREET AND NUMBER | | | | | |
| Frederick | | 20 Lombard Street | | | | | |
| 14. FATHER'S NAME | | First | Middle | | | | |
| T. Clayton | | Stocksdale | 15. MOTHER'S MAIDEN NAME | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 17. INFORMANT | | | | |
| No | | 060-09-4591 | Mrs. James Ely, 1615 Northwick Rd. Balto. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Adenocarcinoma of sigmoid colon 66-5 mos. | | | | | |
| 1533 | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 4, 1968, to Feb 19, 1969, that (I) (we) last saw the deceased alive on Feb 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | Henry V. Chase MD | DEGREE | ATTENDING PHYS. | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) | | Henry V. Chase 804 Toll House Frederick, Md. | | | | | 19 Feb 1969 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIUM | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2/22/69. | New Cathedral Cemetery | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck, Inc. Balto. Md. 21214 | | | DATE FEB 20 1969 | Charles Judge | | | |

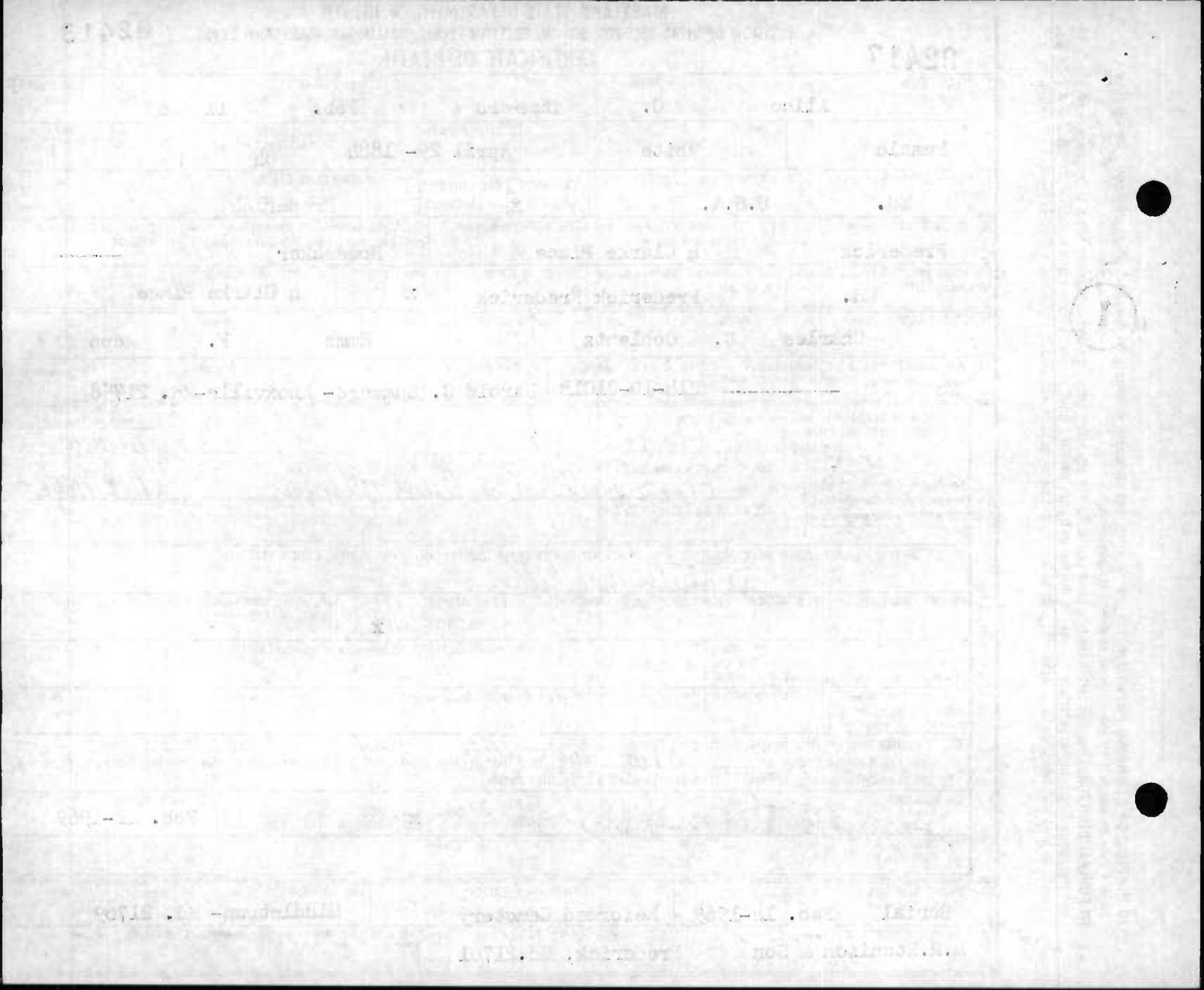
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02413

CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME (Type or print) | | First Alice | Middle G. | Last Summers | 2a. DATE OF DEATH Month Feb. Day 11 Year 69 | 2b. HOUR p.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH April 29- 1884 | 6. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 Clarke Place | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4 Clarke Place | |
| 14. FATHER'S NAME First Charles | | Middle C. | Lost Coblenz | 15. MOTHER'S MAIDEN NAME First Middle Emma | Lost F. | Ropp | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 214-10-2101B | | 17. INFORMANT Harold C. Summers- Knoxville-Md. 21758 | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Cardiac standstill</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i></p> <p><i>4123</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic heart disease</i> <i>months</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>Diabetes mellitus</i></p> | | | | | | | |
| MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 67 , to 8/11 , 19 67 , that (I) (we) last saw the deceased alive on 8/10 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>James B. Thomas, MD</i> | | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED Feb. 12-1969 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL/ CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 14-1969 | 23c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery | | 23d. LOCATION (City or Town) Middletown- Md. (County) (State) 21769 | | |
| 24. FUNERAL DIRECTOR <i>Elwood T.</i> M.R. Etchison & Son | | ADDRESS <i>Mt. Moriah</i> Frederick, Md. 21701 | 25a. REC'D BY REGISTRAR FFC 12 | 25b. REGISTRAR'S SIGNATURE <i>Elwood T.</i> | | | |



FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
2/13/69 kk 02414
02418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--|
| 1. DECEASED-NAME (Type or Print) | | | First Emmett | Middle William | Last Thompson | 20. DATE KNOWN OF DEATH MATED Month 2 Day 5 Year 1969 | Month 2 | Day 5 | Year 1969 | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE White | S. DATE OF BIRTH Oct. 31, 1942 | 6. AGE (In years last birthday) 26 YRS. | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS. HOURS 0 | MIN. 0 | 2c. DATE PRONONCED DEAD Month February Day 5 Year 1969 | | | | 2d. HOUR M | |
| 7a. BIRTHPLACE (State or foreign country) Lawrenceburg, Ind. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Wolfsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before commission STATE Maryland | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Rfd. 2 | | | | | | |
| 14. FATHER'S NAME William | | 15. MOTHER'S MAIDEN NAME Thompson | | Frances | | | | Cline | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16b. SOCIAL SECURITY NO. 311-42-9181 | | 17. INFORMANT Mr. William Thompson, Lawrenceburg, Indiana | | | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE INTOXICATION</u> 9521 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED 6 FEB 69 | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Robert J. Thomas, M. D. Frederick, M.D. | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 2-6-69 | | 23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery | | 23d. LOCATION (City or Town) Aurora, Dearborn Co. Indiana | | (County) | | (State) | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | ADDRESS | | 25a. REC'D. BY REGISTRAR FEB 10 1969 | | 25b. REGISTRAR'S SIGNATURE Walter B. B. B. | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02415

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/transit, or removal, and in any event, within 72 hours after death.

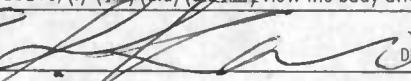
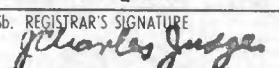
| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------|
| 1. DECEASED-NAME (Type or print) | First Carroll | Middle Charles | Last Topper | 2a. DATE OF DEATH Month February | Day 4 | Year 1969 | 2b. HOUR 8: A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH February 17, 1918 | | | 6. AGE (In years last birthday) 50 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Adams Co. Pa. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Emmitsburg, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) South Seton Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver | | | 12b. KIND OF BUSINESS OR INDUSTRY Dairy |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Frederick | 13c. CITY OR TOWN Emmitsburg | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 221 North Seton Ave. | | | |
| 14. FATHER'S NAME James R. Topper | First Middle Last | 15. MOTHER'S MAIDEN NAME Stella | | | Middle | Last Wolfe | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) W.W.2 | 17. INFORMANT Mrs. Carroll C. Topper, 221 N. Seton Ave. | | | Address Emmitsburg, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i> 398X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 398X (b) <i>Arthritic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>5/12</i> , 19 <i>69</i> , to <i>5/3</i> , 19 <i>69</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>5/12/69</i> , 19 <i>69</i> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>George L. Moringstar</i> | | 22c. DEGREE ATTENDING PHYS. | | <input type="checkbox"/> MED. DIRECTOR | <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <i>2/4/69</i> | |
| 22d. PHYSICIAN'S NAME (Type) George L. Moringstar | | 22e. ADDRESS Emmitsburg, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 7, 1969 | 23c. NAME OF CEMETERY OR CREMATORIAL New St. Joseph's Catholic | | 23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md. | | |
| 24. FUNERAL DIRECTOR Clarence E. Wilson | | ADDRESS Emmitsburg, Md. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| Clarence E. Wilson | | | | DATE FEB 7 1969 | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02416

4
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. DECEASED-NAME (Type or print) MEREDITH LORENZO WHISNER | | | | 2a. DATE OF DEATH 2 Month 15 Day 69 Year | 2b. HOUR 5 P.M. |
| 3. SEX male | 4. RACE white | S. DATE OF BIRTH II-4-16 | 6. AGE (in years at birthday) 52 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) West Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | Md. | |
| 10. CITY OR TOWN OF DEATH Brunswick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 501 Brunswick St., B&O Railroad | 12a. USUAL OCCUPATION (Kind of work done or retired.) retired | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STAFF | 13b. COUNTY Frederick | 13c. CITY OR TOWN Brunswick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 501 Brunswick St. | |
| 14. FATHER'S NAME Raymond | First Theodore | Middle Whisner | Last | 15. MOTHER'S MAIDEN NAME Nellie | Middle A. Last Smith |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 232-26-7912 | 17. INFORMANT Pearl I. Whisner-Brunswick, Md. | Address | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> 1541 lost. | | | | 2 days | |
| (b) Abdominal Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Rectal Carcinoma | | | | 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| MEDICAL CERTIFICATION 2 | | 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) <input type="checkbox"/> (We) <input type="checkbox"/> attended the deceased from Feb. 9, 1969 , to Feb. 15, 1969 , that (I) <input type="checkbox"/> (We) <input type="checkbox"/> last saw the deceased alive on Feb. 15, 1969 , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (We) <input type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE  | | | 22c. DATE SIGNED Feb. 17, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. | 22e. ADDRESS Gum Spring Hollow, Brunswick, Md. | | | | |
| 23a. BURIAL CREMATION REMOVAL Burial | 23b. DATE 2/19/69 | 23c. NAME OF CEMETERY OR CREMATORIUM Mt. Nebo Church Cemetery | 23d. LOCATION (City or Town) Great Cacapon | (County) W.Va. | (State) |
| 24. FUNERAL DIRECTOR Feeete Funeral Home | ADDRESS Brunswick, Md. | 25a. REC'D BY REGISTRAR DATE FEB 20 1969 | 25b. REGISTRAR'S SIGNATURE  | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR p 1969 4:05M | |
| U - OTTO - C. | | Wiegand, Sr. | | February 4 1969 | | | |
| 3. SEX Male | | 4. RACE White | | S. DATE OF BIRTH November 20, 1888 | 6. AGE (In years last birthday) 80 | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Braddock Heights | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Vindabona Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter -Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Md. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 115 S. Market Street | |
| 14. FATHER'S NAME First Paul | | Middle Wiegand | | 15. MOTHER'S MAIDEN NAME First Emma | Middle Jane | Last Slick | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 433 9 | | 17. INFORMANT Robert Wiegand, Braddock Heights, Maryland | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mi | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF (c) | | 5 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senile Bynocrosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/31/1969</u> to <u>4/31/1969</u> , that (I) (we) last saw the deceased alive on <u>4/1/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>A. T. Brice</i> | | DEGREE ATTENDING PHYS. | <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 2/5/69 | |
| 22d. PHYSICIAN'S NAME (Type) A. T. Brice, M.D. | | 22e. ADDRESS Jefferson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 7, 1969 | 23c. NAME OF CEMETERY OR CEMINATORY Mount Olivet Cemetery | | 23d. LOCATION (City or Town) Frederick | (County) Frederick | (State) Md. |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. | | ADDRESS <i>Donald M. Fadley</i> | | 25a. REC'D BY REGISTRAR DATE FEB 10 1969 | 25b. REGISTRAR'S SIGNATURE <i>W. E. Etchison</i> | | |

FOR STATE
HEALTH DEPT.

2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2
Item 7a, FilmGull
4/17/69jp MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02418

2
02428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------|---------------------------------------------------------------|------|-------------------------------------------------|
| 1. DECEASED-NAME (Type or Print) | | First Middle Last | | | 20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 1 69 | | | 2b. HOUR 11:5 | | |
| Jessie Elmer Wolfe | | | | | MONTHS | IF UNDER 1 YEAR 1 | IF UNDER 24 HRS. 19 | | | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH 12/11/1968 | | 6. AGE (In years lost birthday) — yrs. | | | MONTHS | HOURS | MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick | | | 2c. DATE PRONOUNCED DEAD Month Day Year Feb. 1, 1969 19 | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13c. CITY OR TOWN Fred. Thurmont | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER RD 2 | | | | | |
| 14. FATHER'S NAME Sidney Jessie Wolfe | | 15. MOTHER'S MAIDEN NAME Mary C. Shriner | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Sidney J. Wolfe | | | ADDRESS Thurmont, Md. RD 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE TRACHEOBRONCHITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION MEDICAL CERTIFICATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Robert J. Thomas</u> EXAMINER'S NAME (Type) Robert J. Thomas | | | | | | | | | | 22b. DATE SIGNED Feb. 1, 1969 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-3-69 | | 23c. NAME OF CEMETERY OR CREMATORIAL BROWN CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) FOXVILLE FREDK CO. MD | | | |
| 24. FUNERAL DIRECTOR Raymond E. Greager | | ADDRESS Thurmont, Md. | | 25a. FEB REGISTRAR DATE FEB 0 1969 | | | 25b. REGISTRAR'S SIGNATURE <u>Raymond E. Greager</u> | | | |

222

Doris Young
100-1010-1020
24 hours after death
Death certificate filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

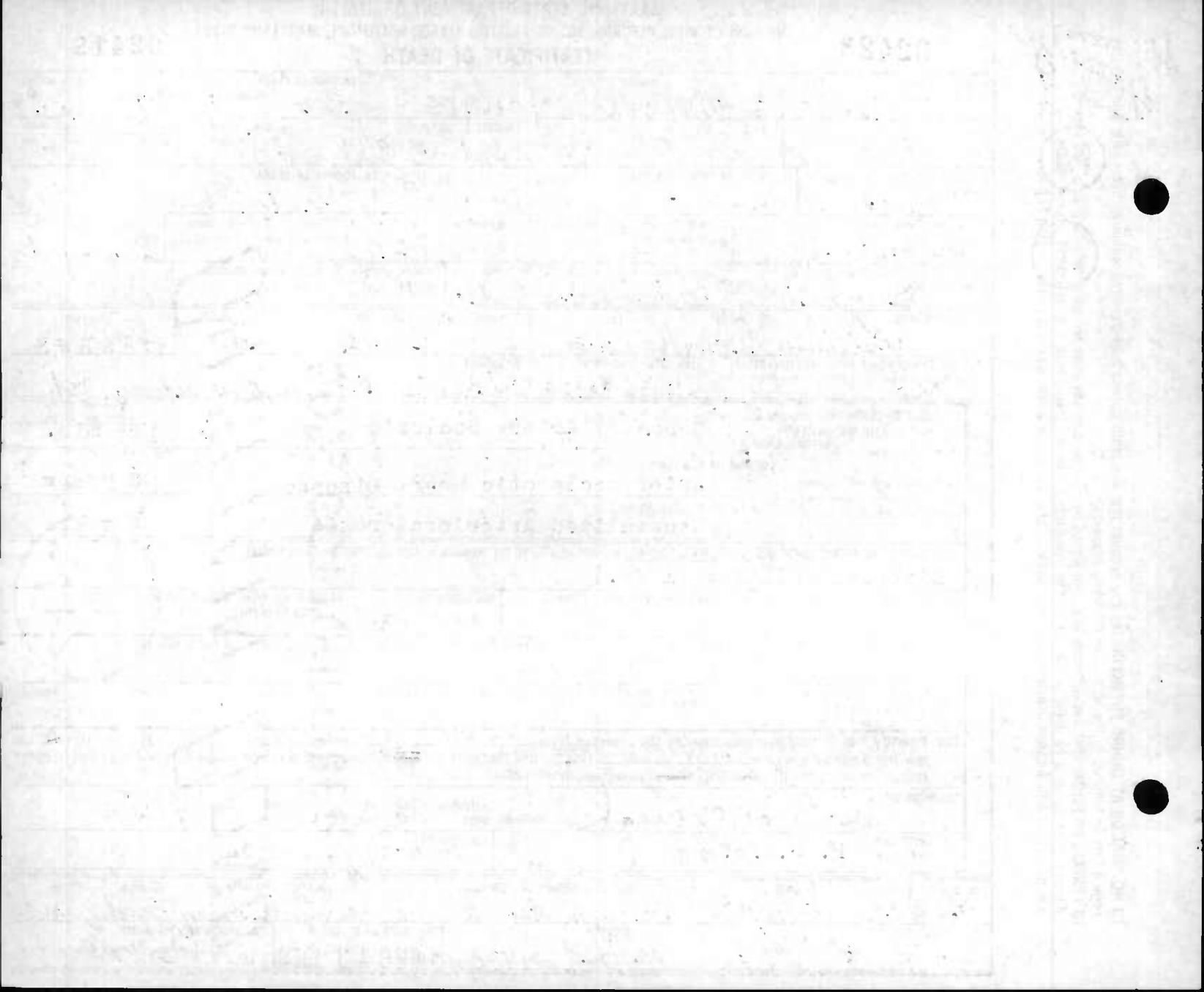
CERTIFICATE OF DEATH

02419

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------|
| 1. DECEASED NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH Month | 2b. HOUR A.M. 10:30 M | | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | 7. IF UNDER 1 YEAR MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| No | | 214-36-8632 A | | Mrs Pauline Whitmore, New Midway, Md. | | Few min. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: Coronary Artery Occlusion | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease 5 years | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis 5 years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) | | | | | | | | |
| Diabetes Mellitus (1 Yr.) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14/1965 to 2/9/1969, that (I) () lost saw the deceased alive on 2/8/1969, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did) () view the body after death. | | | | | | | | |
| 22b. SIGNATURE R. S. McVaugh | | 22c. DATE SIGNED 2/11/69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | R. S. McVaugh | | 22e. ADDRESS | | Taneytown, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 2/11/69 | | Haugh's Cemetery | | In Ladysburg Fred., Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR Y.C. Barton, Walkersville, Md. 21793 | | | | | | 25b. REGISTRAR'S SIGNATURE Pauline Justice |
| 26. DATE FEB 13 1969 | | | | | | | | |

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

02424

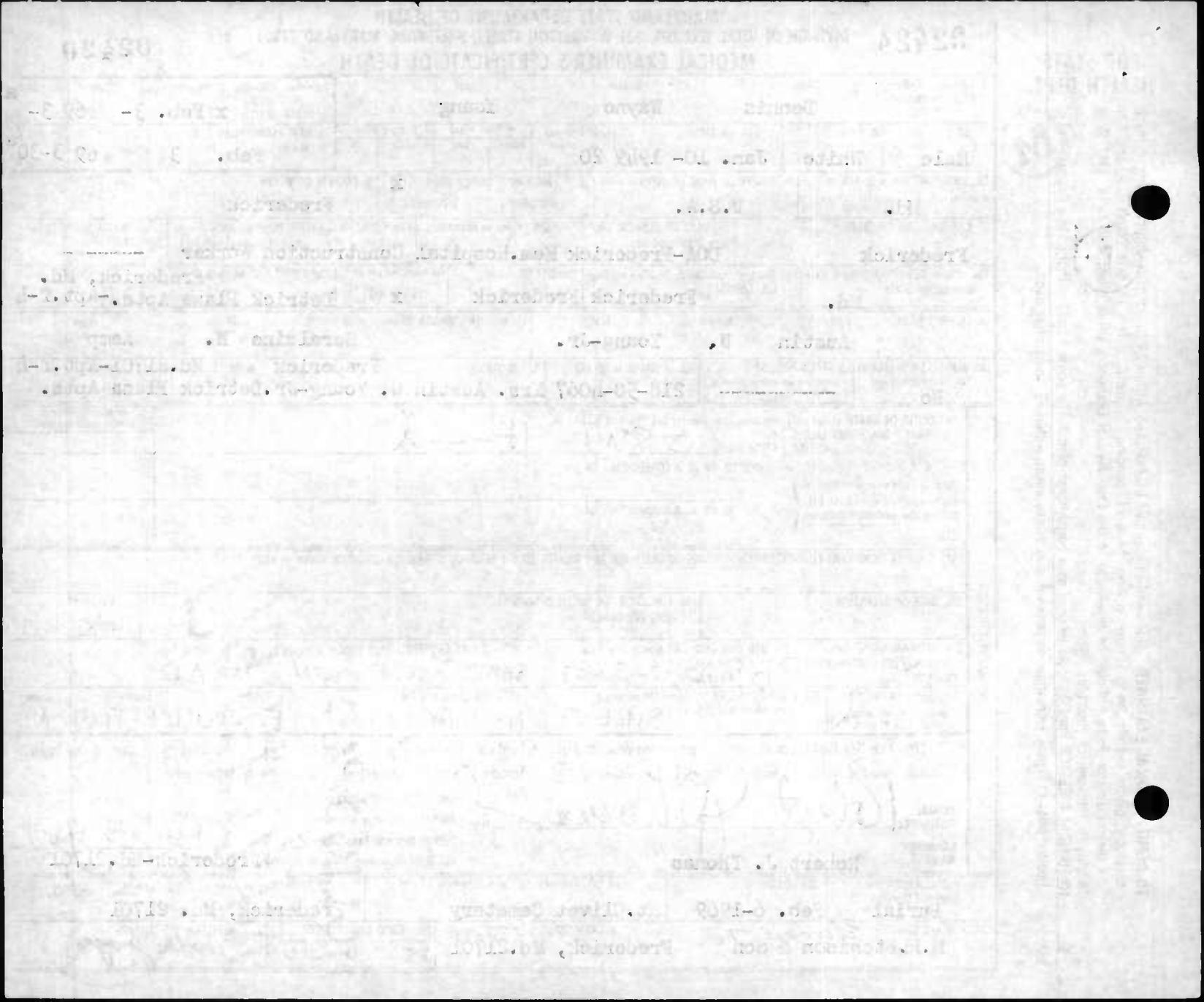
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02420

Any delay is
Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page
5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------|
| 1. DECEASED NAME (Type or Print) | | First Dennis | Middle Wayne | Last Young | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Feb. 3- 1969 | Month Day Year 3 - 19 69 | 2b. HOUR 3 - M | |
| 3. SEX | 4. RACE | S. DATE OF BIRTH Jan. 10- 1949 | 6. AGE (In years last birthday) 20 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year Feb. 3 1969 | | |
| Male | White | | | | | 2d. HOUR 3-30 M | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DUA-Frederick Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction Worker | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER Frederick, Md. Detrick Plaza Apts. - Apt. T-4 | |
| 14. FATHER'S NAME Austin | | Middle U. | Last Young-Jr. | 15. MOTHER'S MAIDEN NAME Geraldine N. | | 16. ADDRESS Md. 21701-Apt. T-4 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 218-50-4067 | | 17. INFORMANT Mrs. Austin U. Young-Jr. Detrick Plaza Apts. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>68W</u> Head 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 3 P.M. 2-3 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) SHOT SELF IN HEAD | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) STREET | | 21f. LOCATION Street or R.F.D. No. N. MARKET ST. - FREDERICK - MD | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | | 22b. DATE SIGNED FEB. 3 1969 | | |
| ACTUAL SIGNATURE Robert J. Thomas | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Frederick, Md. 21701 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 6-1969 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) Frederick, Md. 21701 | | (County) (State) |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | | ADDRESS Frederick, Md. 21701 | | 25a. REC'D BY REGISTRAR FEB 6 1969 | | 25b. REGISTRAR'S SIGNATURE Robert J. Etchison | | |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02421

02425

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR 8 P.M. | | | |
| Mary | | | E | Ziegler | 2 19 69 | | | | | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) 83 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | |
| Female | | White | 4/20/1885 | | | YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Maryland | | Frederick | | | | Frederick | | | | |
| 10d. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Braddock Hts., Md | | Vinebana, Inc. | | | Homemaker | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | | |
| Maryland | | Frederick | | | Frederick | 714 N. Market Street | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First | Middle | Last | | |
| | | James | A. | Colliflower | Jane | | | Eyler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | 212-10-0561 | | | Mr. H. David Hagan | | | 407 N. Market St. Fred. Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis Obstruction</u> 5 days | | | | | | | | | | |
| 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Segmentation Pulm</u> 1 year (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| <u>Advanced Arteriosclerosis</u> <u>Senile Dementia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | |
| 22o. I certify that (I) (this hospital) attended the deceased from <u>June, 1968</u> , to <u>2/14, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>R. Talbott Brice</u> | | 22c. DATE SIGNED Feb. 19, 1969 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | Dr. A. Talbott Brice | M.D. | 22e. ADDRESS | | | Jefferson, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| Burial | | 2-21-1969 | Mount Olivet Cemetery | | | Frederick, Frederick, Md. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | Robert E. Dailey & Son | | | FEB 21 1969 | | | | | |

